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(12) **United States Patent**  
**Kwan**

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(45) **Date of Patent:** **Aug. 6, 2013**

(54) **DENTAL IMPLANT SYSTEM AND  
ADDITIONAL METHODS OF ATTACHMENT**

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patent is extended or adjusted under 35  
U.S.C. 154(b) by 0 days.

(21) Appl. No.: **13/025,481**

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(65) **Prior Publication Data**

US 2011/0129799 A1 Jun. 2, 2011

**Related U.S. Application Data**

(63) Continuation of application No. 11/288,465, filed on  
Nov. 29, 2005, now abandoned, which is a  
continuation-in-part of application No. 10/195,007,  
filed on Jul. 12, 2002, now Pat. No. 7,207,800, which is  
a continuation-in-part of application No. 09/967,556,  
filed on Sep. 28, 2001, now abandoned.

(60) Provisional application No. 60/237,222, filed on Oct.  
2, 2000, provisional application No. 60/236,518, filed  
on Sep. 29, 2000.

(51) **Int. Cl.**  
**A61C 8/00** (2006.01)

(52) **U.S. Cl.**  
USPC ..... 433/174

(58) **Field of Classification Search**

USPC ..... 433/172-176  
See application file for complete search history.

(56) **References Cited**

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| 6,217,331    | B1   | 4/2001  | Rogers et al. |       |         |
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| 2002/0182567 | A1 * | 12/2002 | Hurson et al. | ..... | 433/173 |
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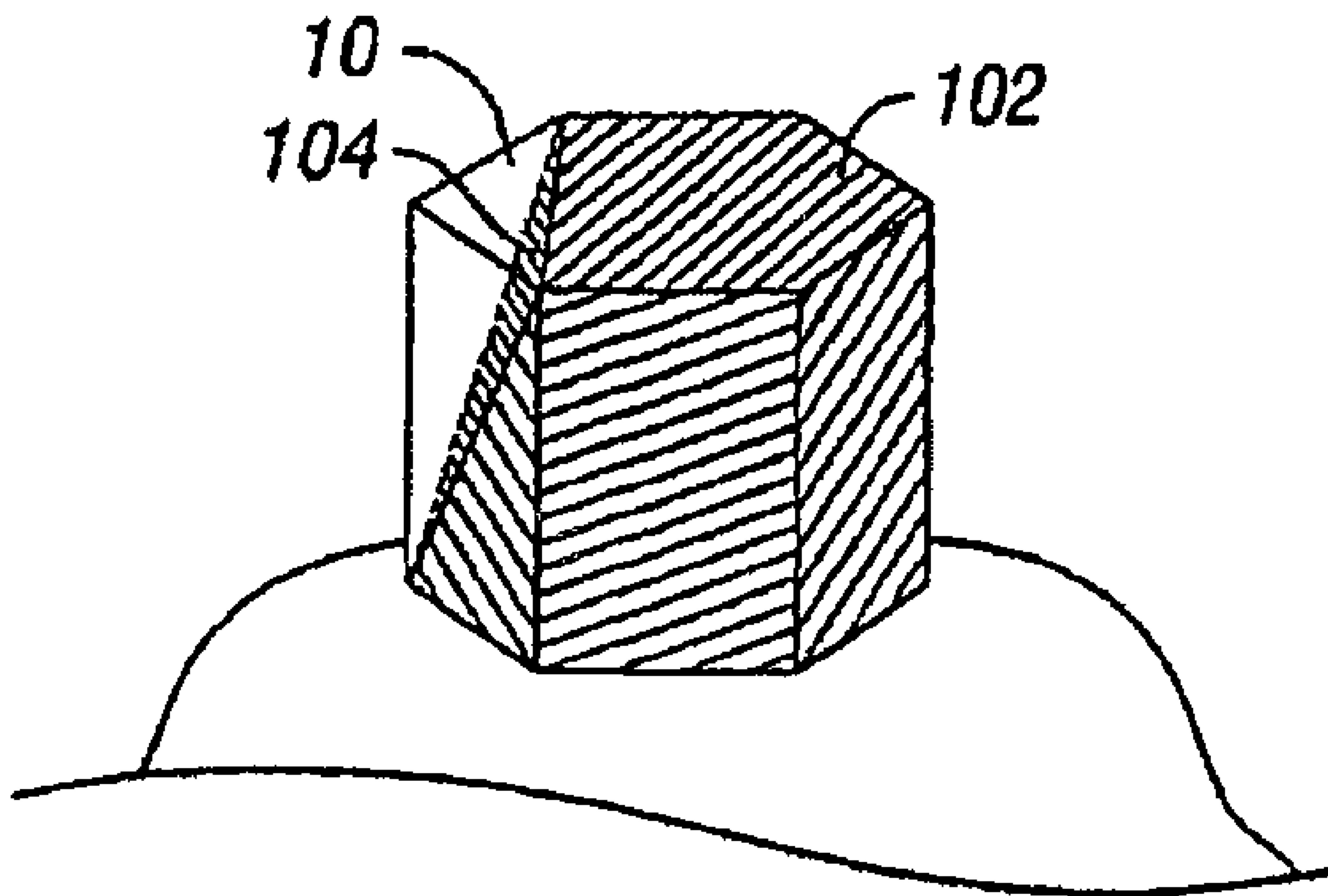
*Primary Examiner* — Sunil K Singh

(74) *Attorney, Agent, or Firm* — Hiscock & Barclay, LLP

(57) **ABSTRACT**

Disclosed in this specification is a dental implant assembly  
with an abutment head integrally joined to an implant body.  
The top section of the abutment head a shape formed by a  
linear wall adjacent to an arcuate wall; a ledge is located  
beneath the top section of the abutment; and the abutment  
head extends above the ledge a distance of from about 1.5 to  
about 10 millimeters. The implant body has a base section and  
a neck section, each of which has a different degree of rough-  
ness.

**20 Claims, 40 Drawing Sheets**



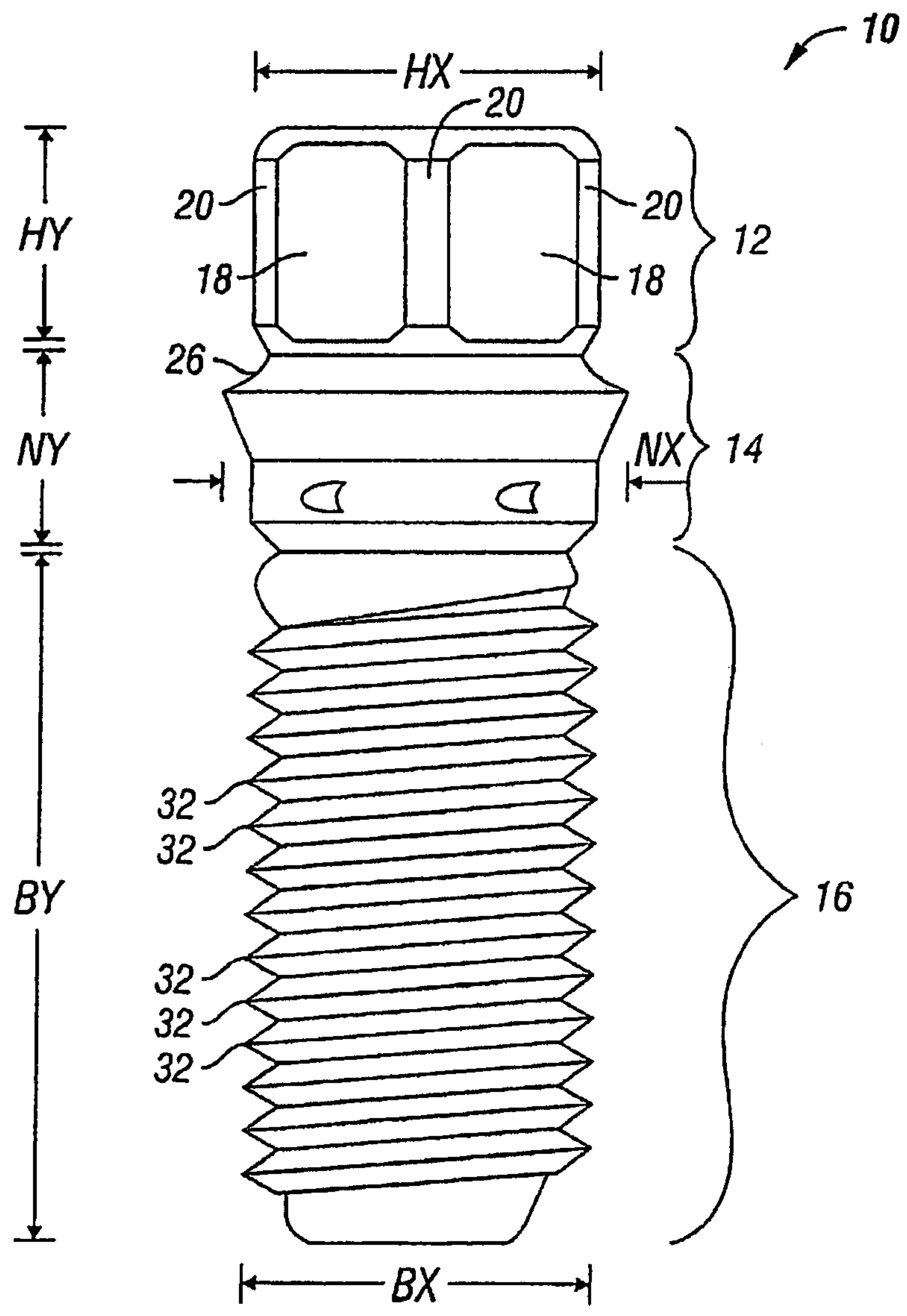


FIG. 1A

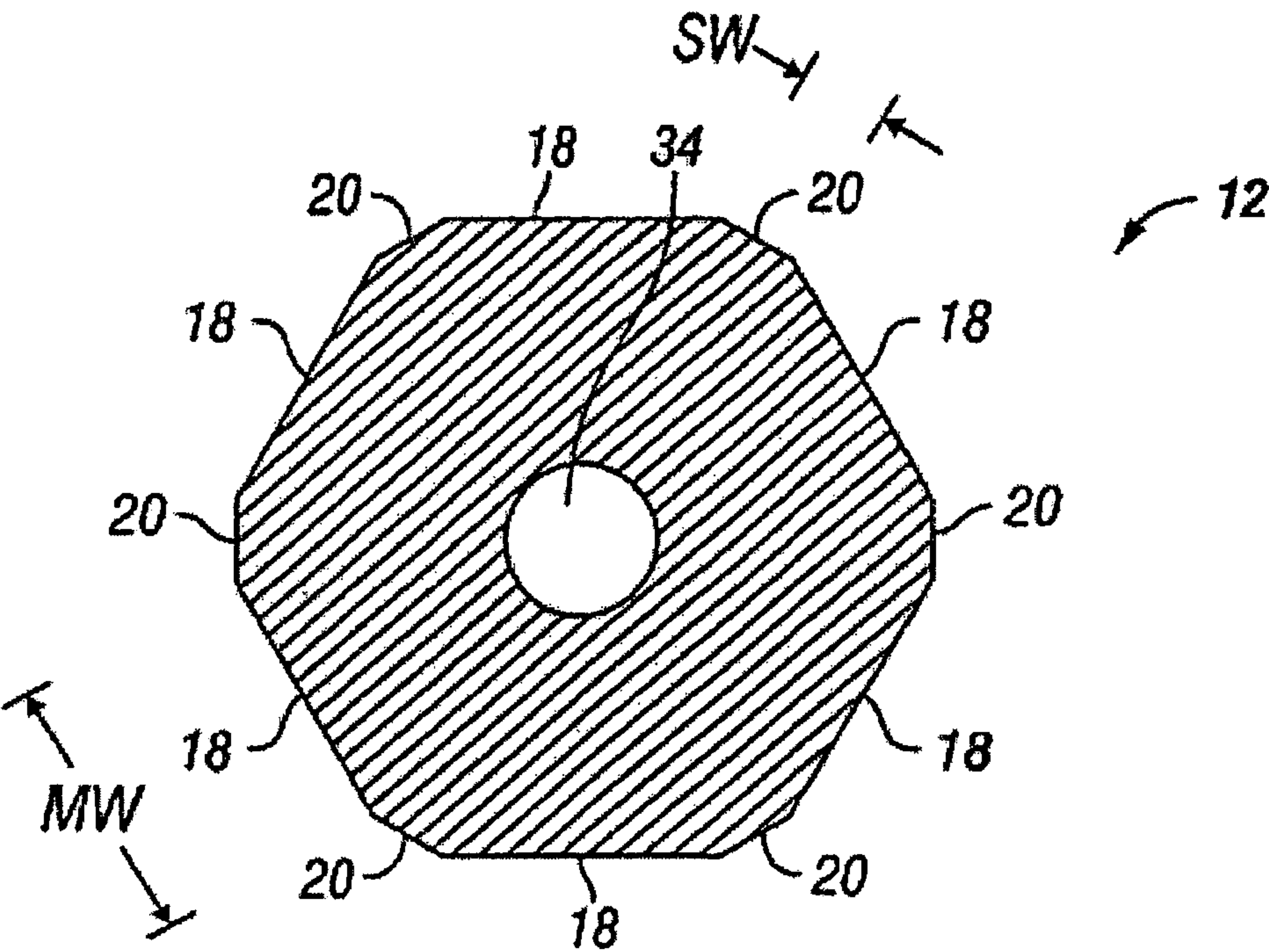
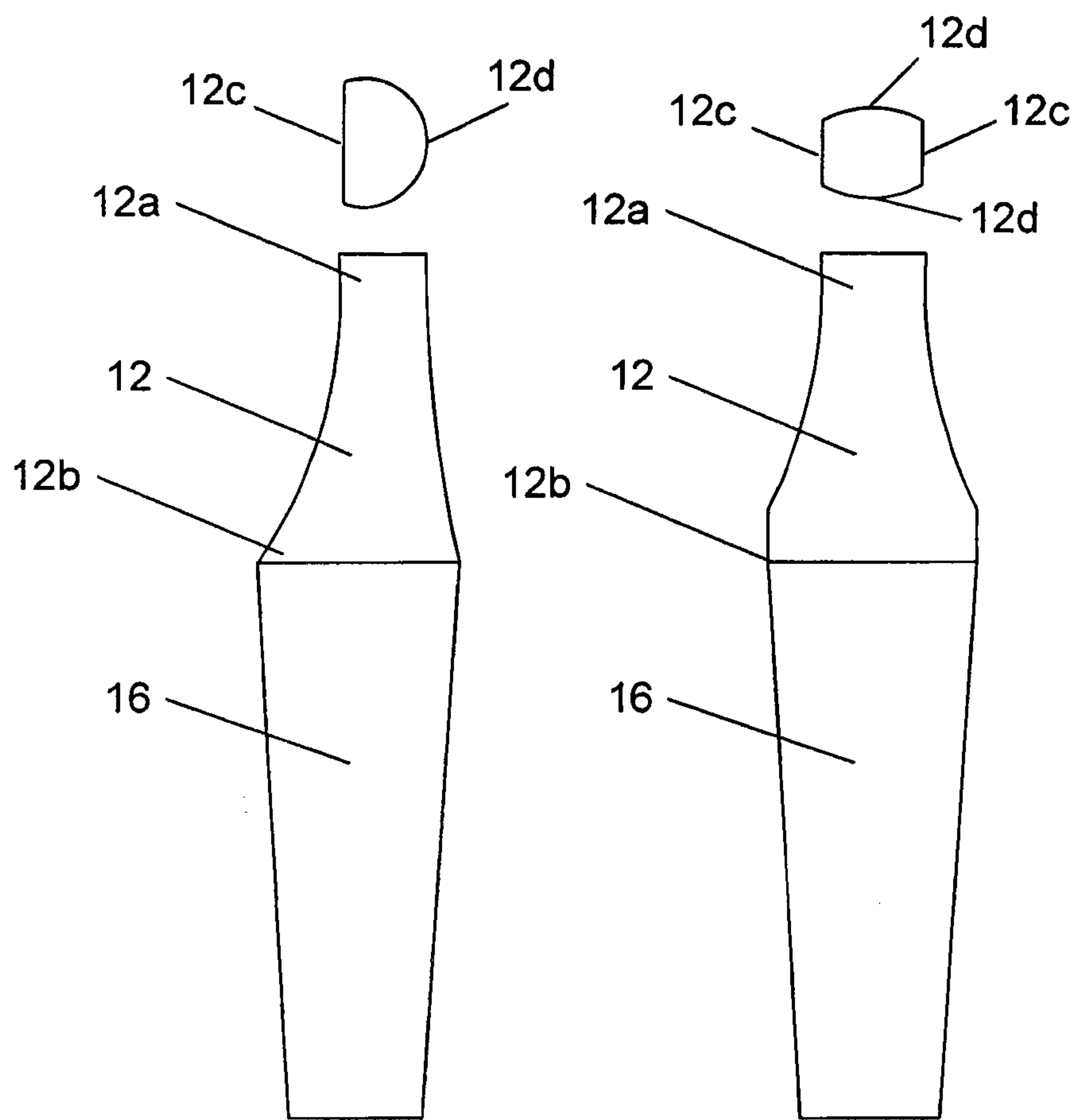
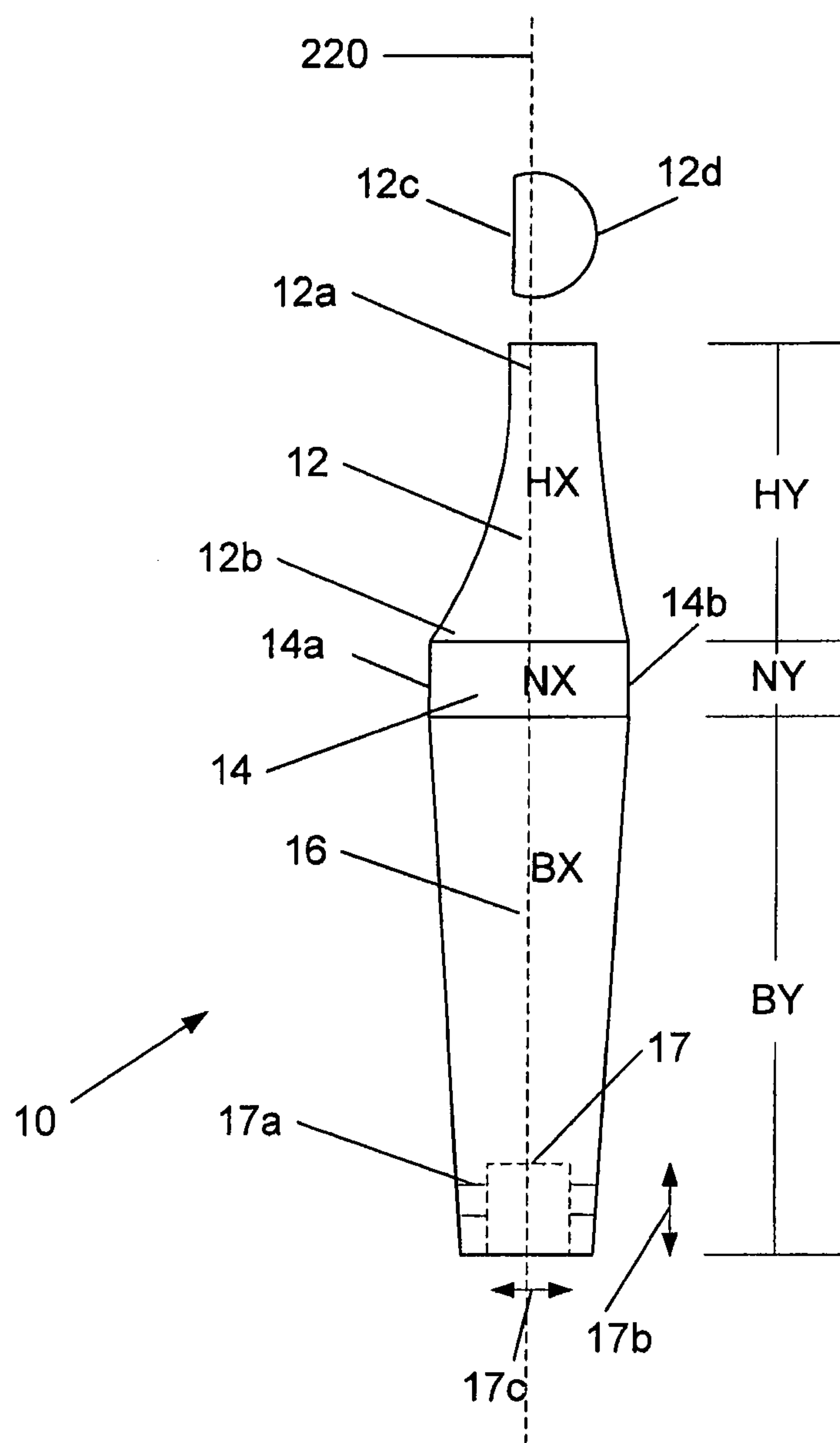


FIG. 1B

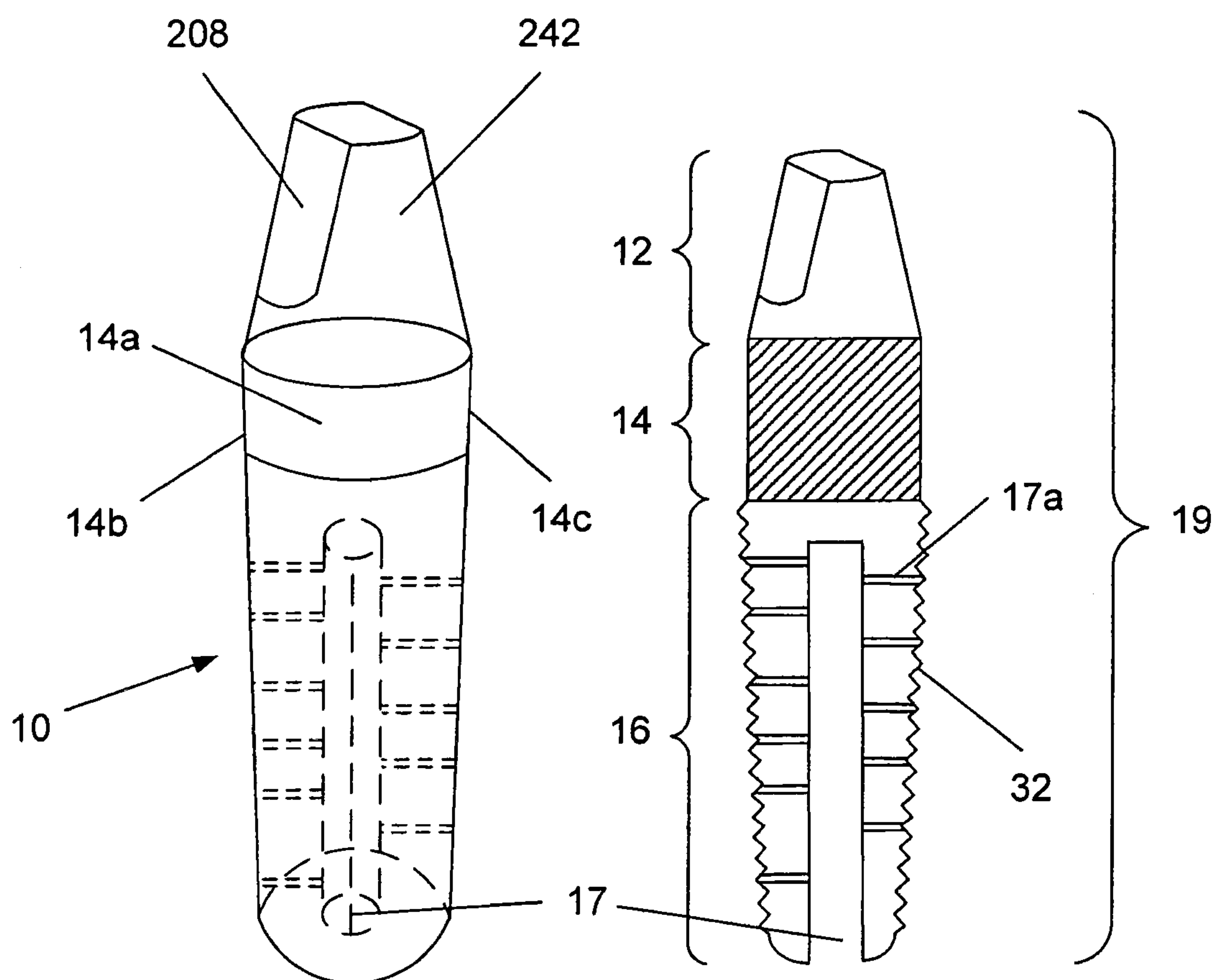


**FIG. 1C**

**FIG. 1D**



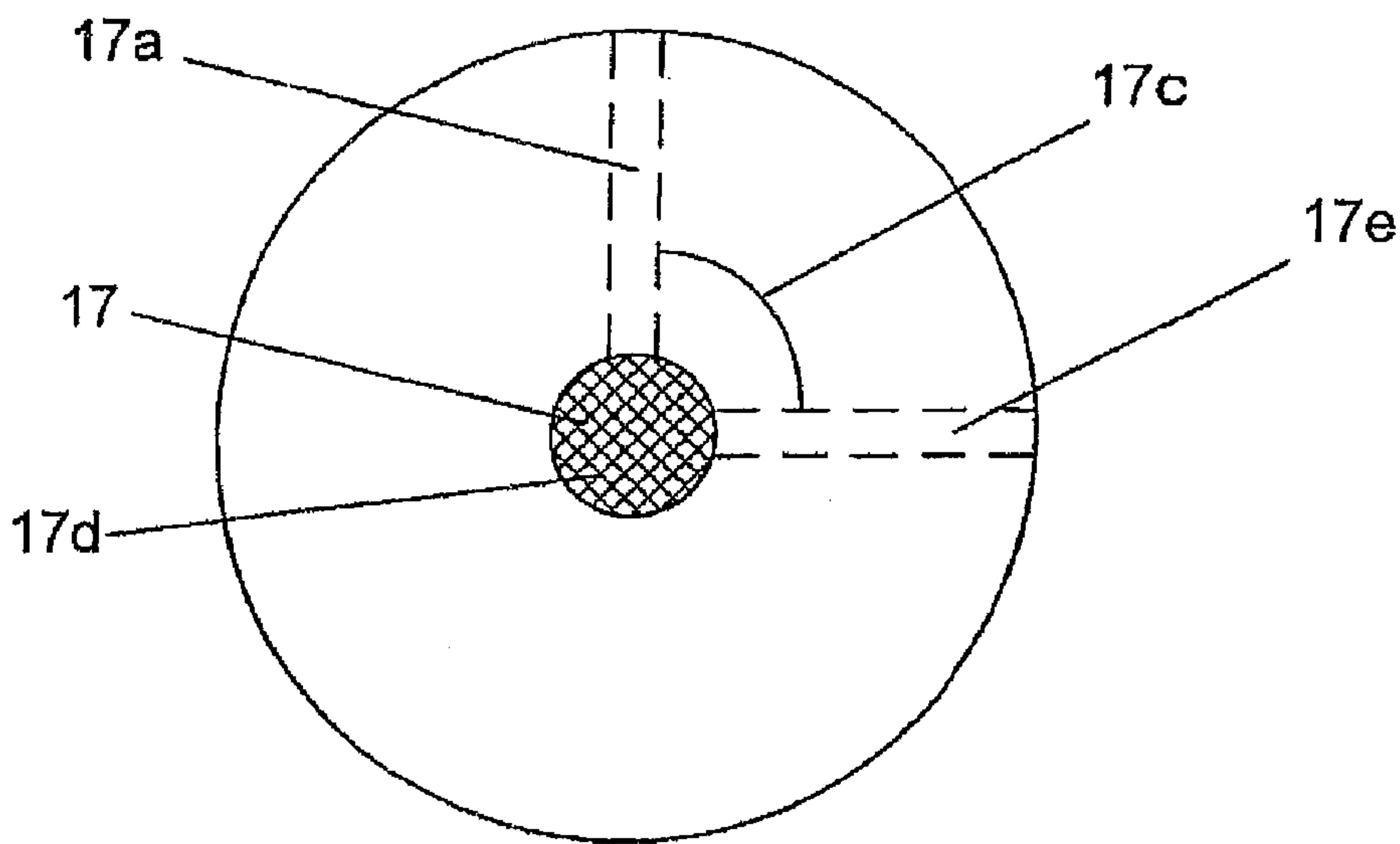
**FIG. 1E**



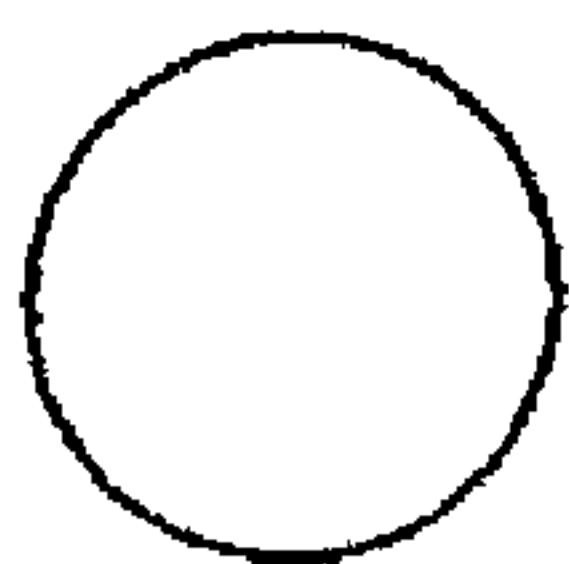
**FIG. 1F**

**FIG. 1G**

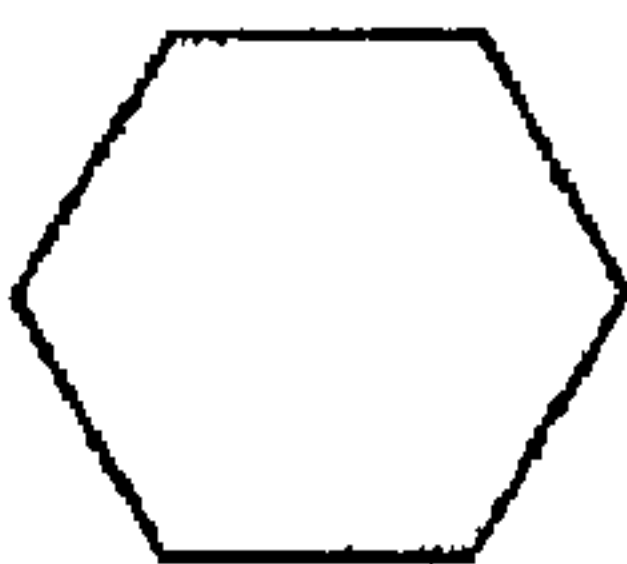




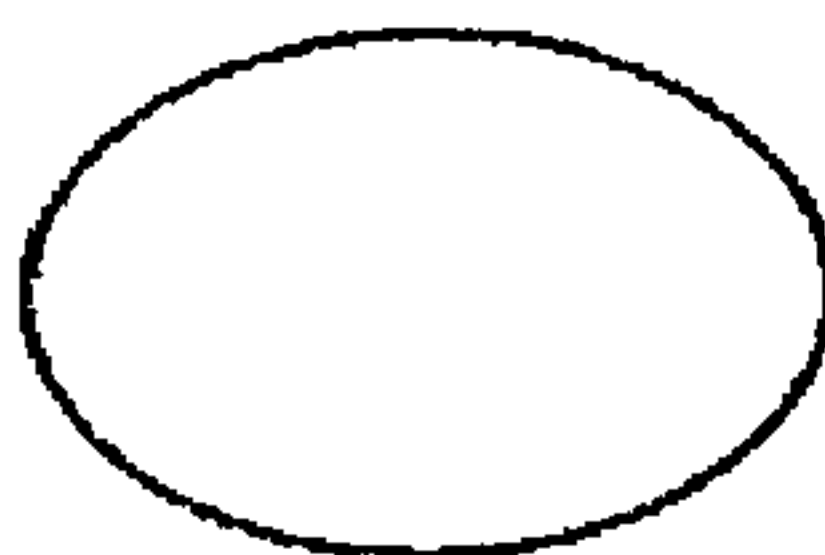
**FIG. 1H**



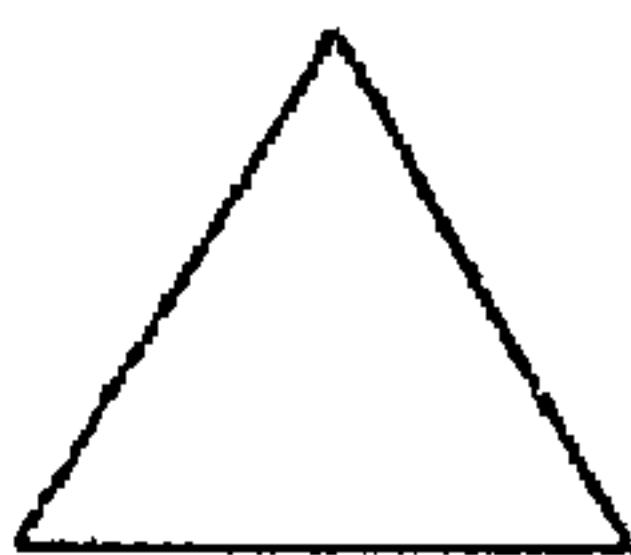
**FIG. 1I**



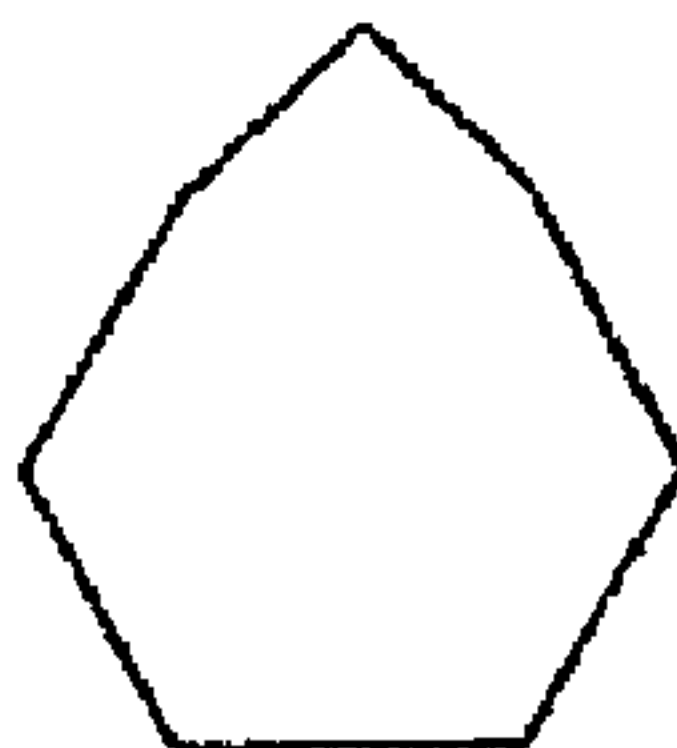
**FIG. 1J**



**FIG. 1K**



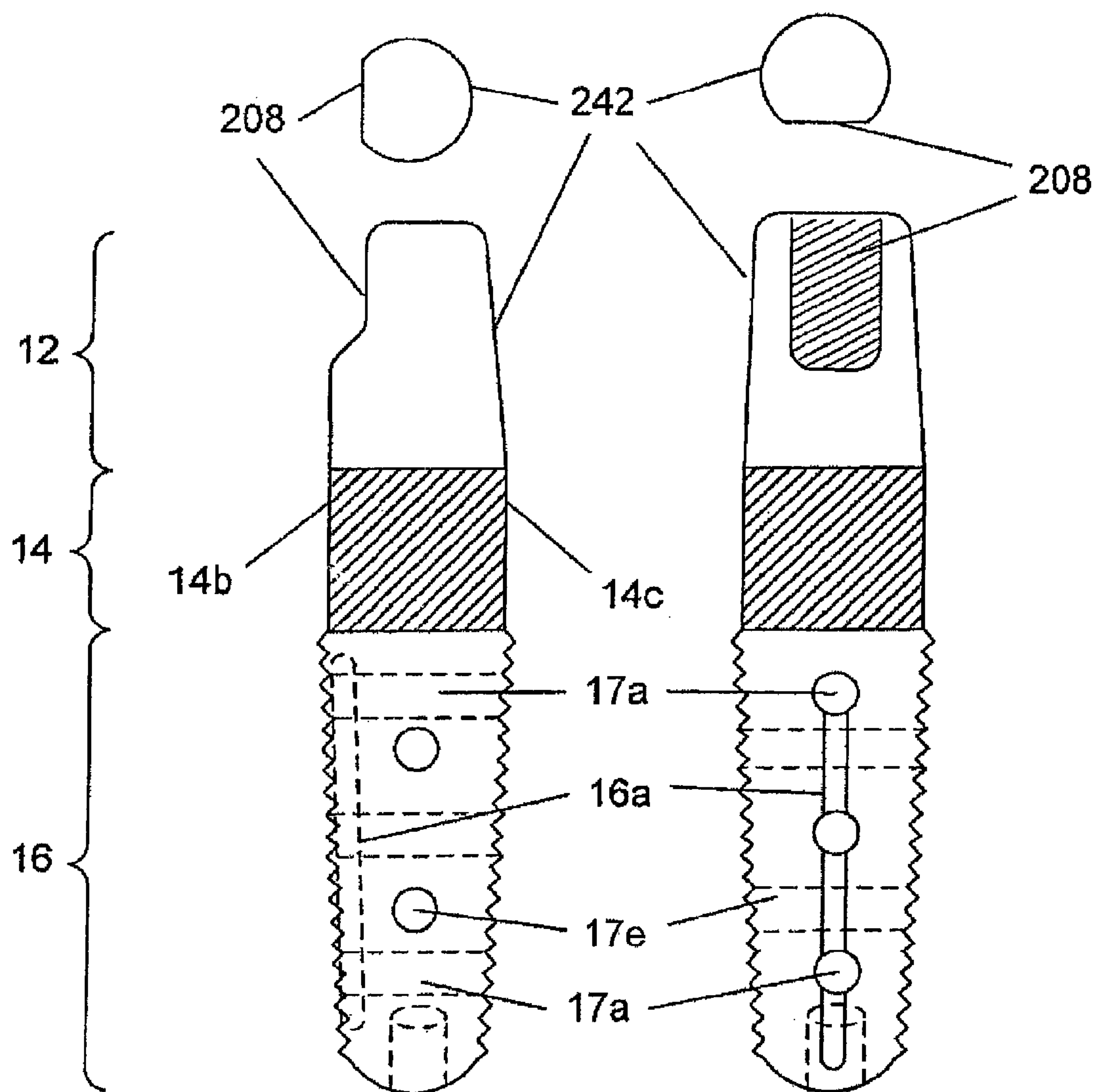
**FIG. 1L**



**FIG. 1M**



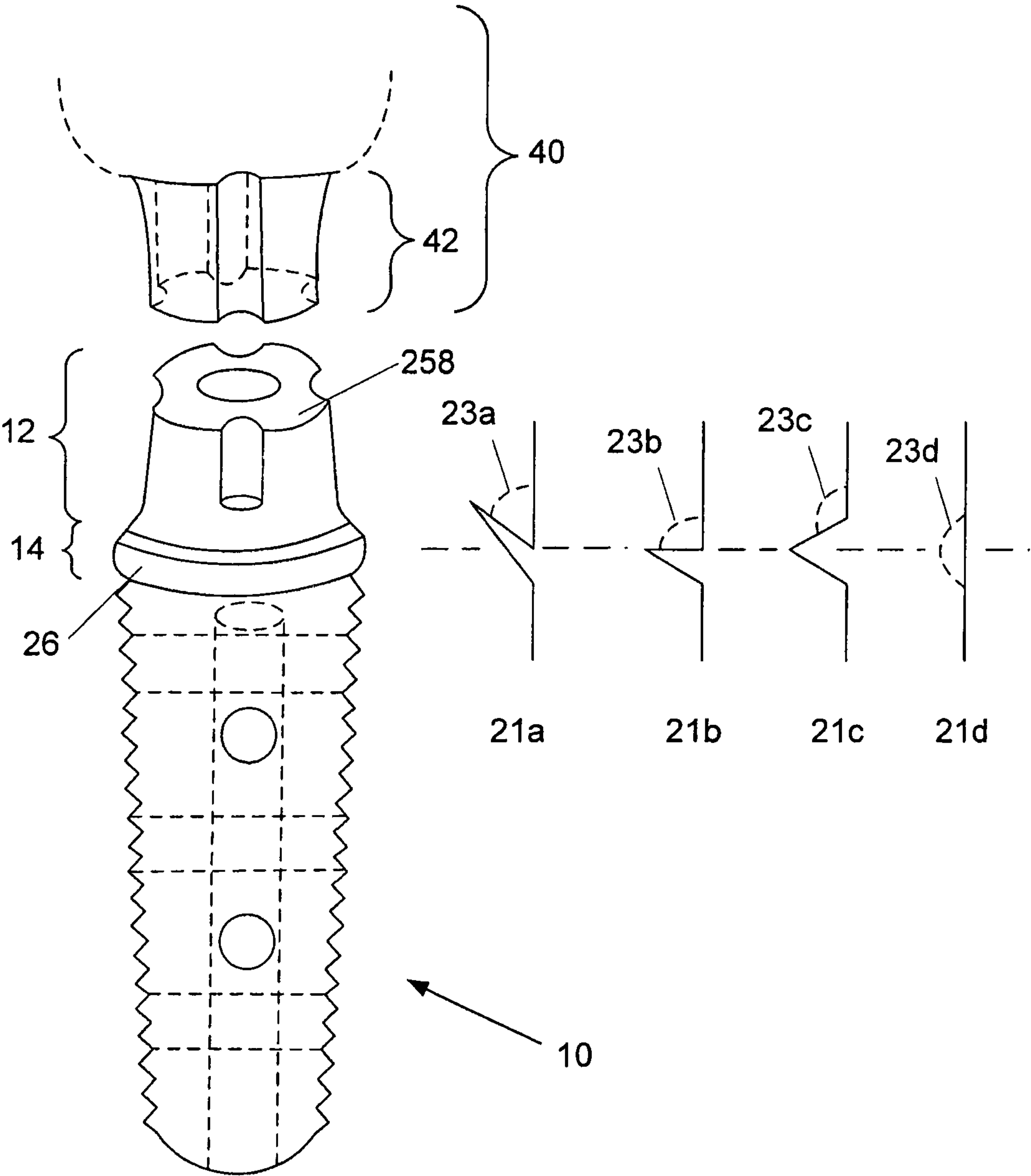
**FIG. 1N**



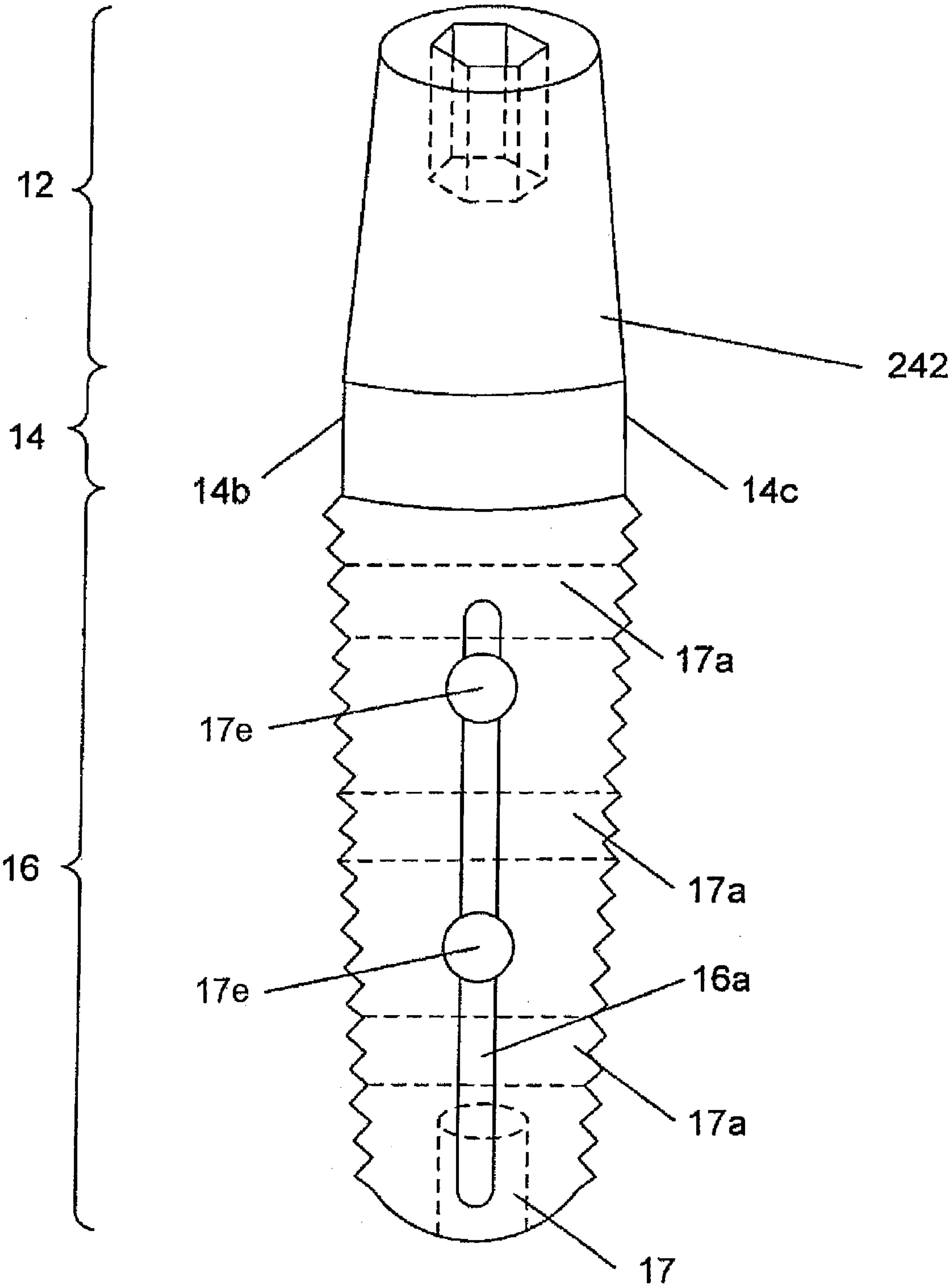
**FIG. 10**

**FIG. 1P**

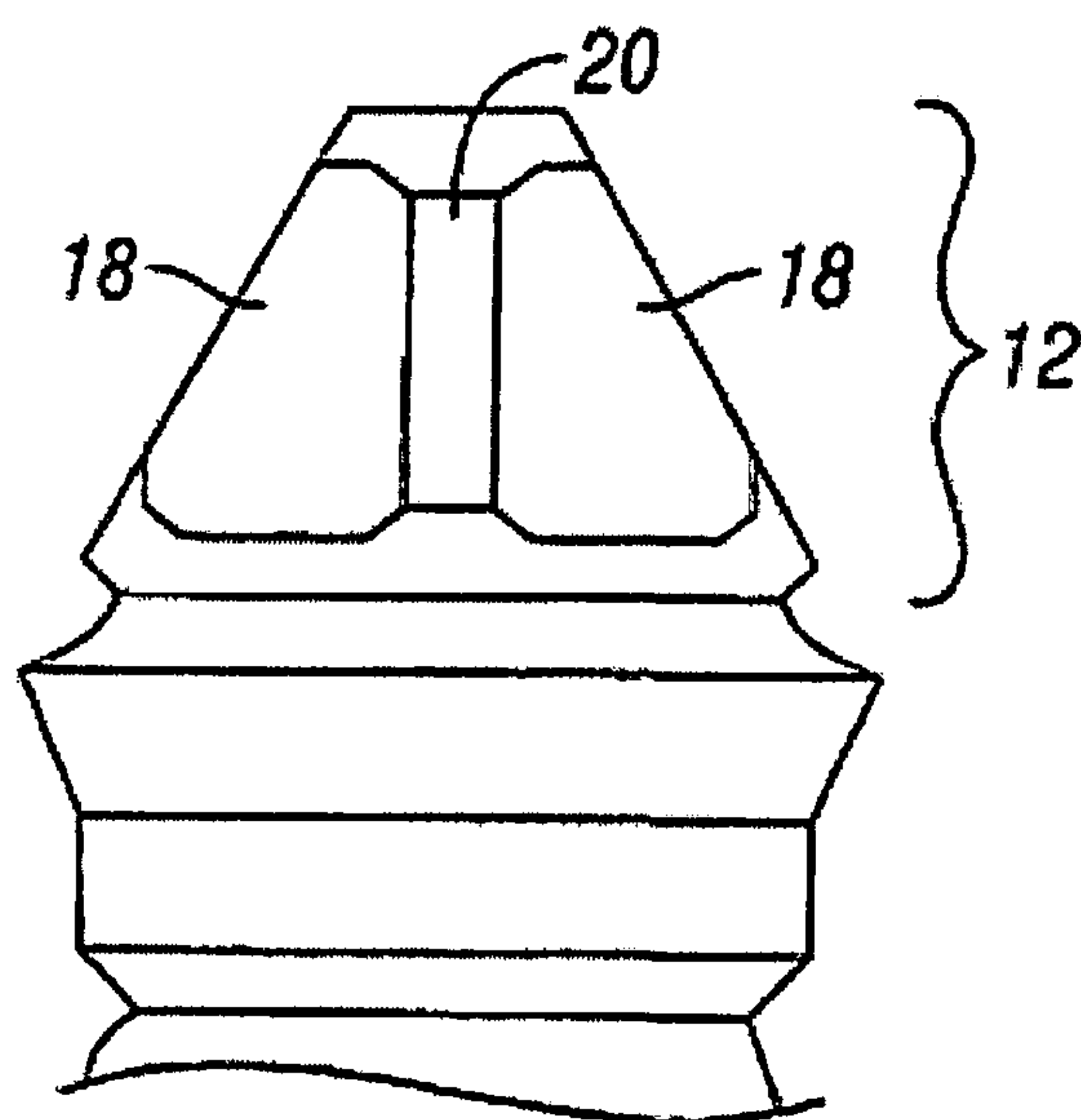




**FIG. 1Q**



**FIG. 1R**



**FIG. 2**

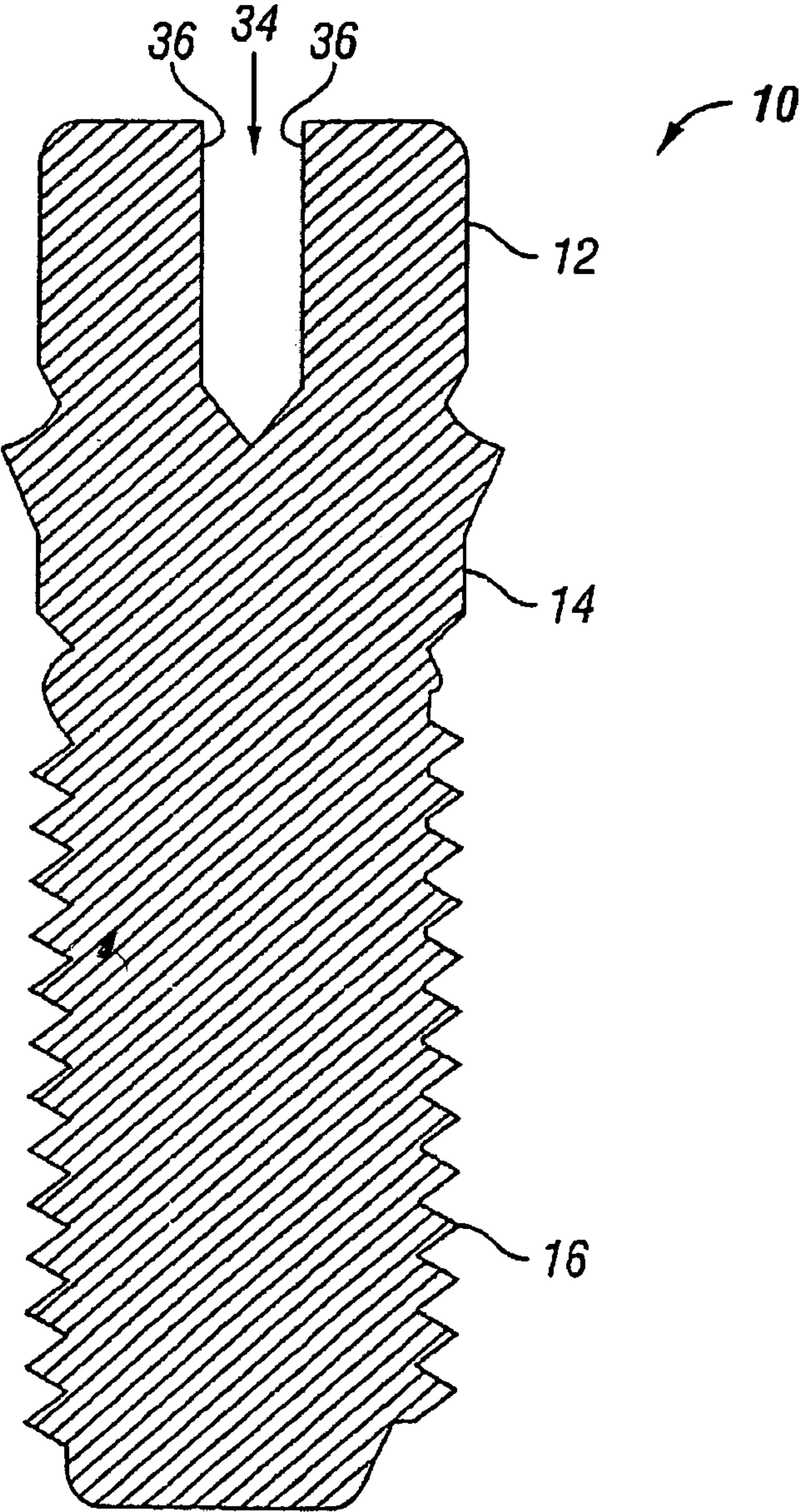
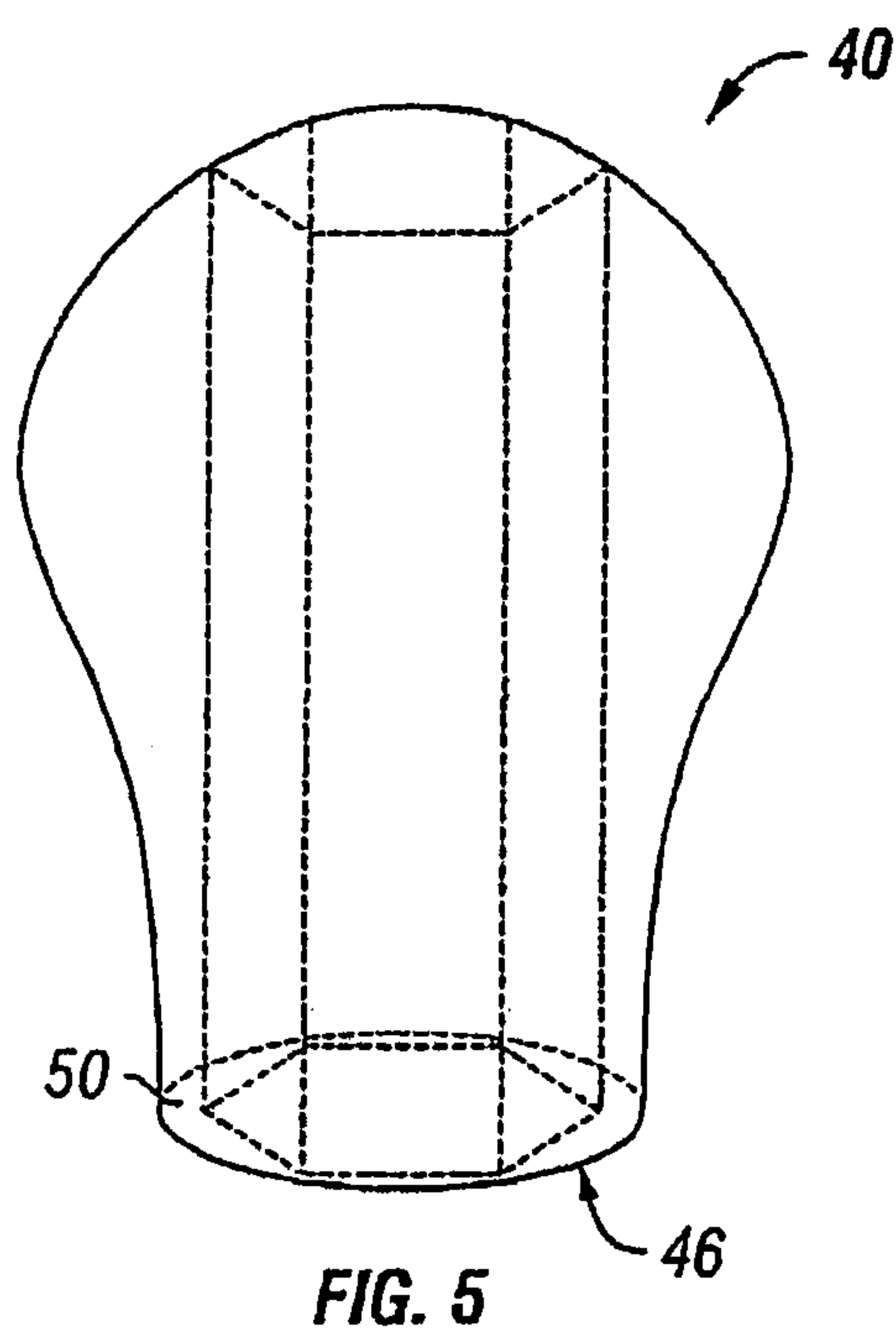
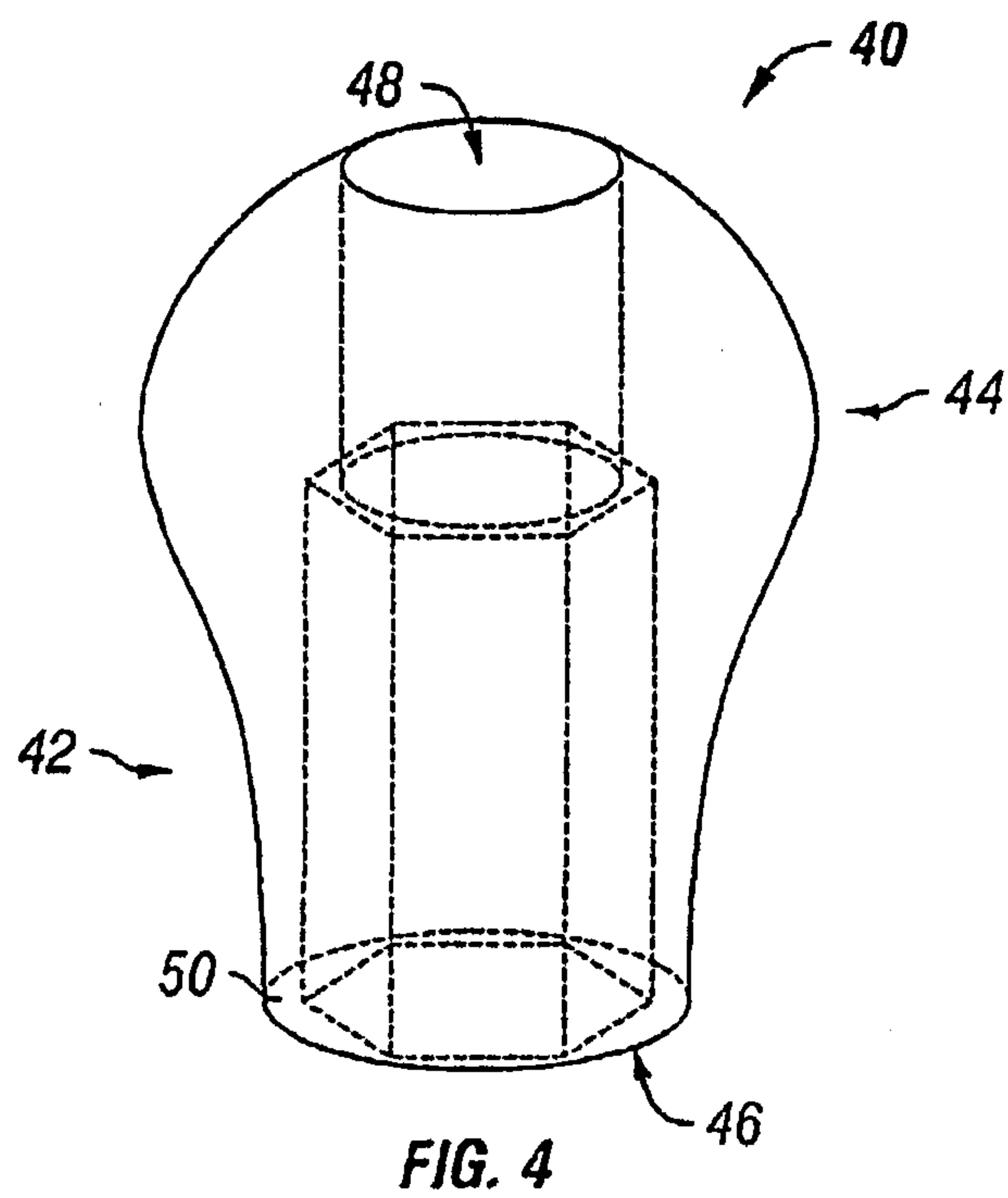


FIG. 3



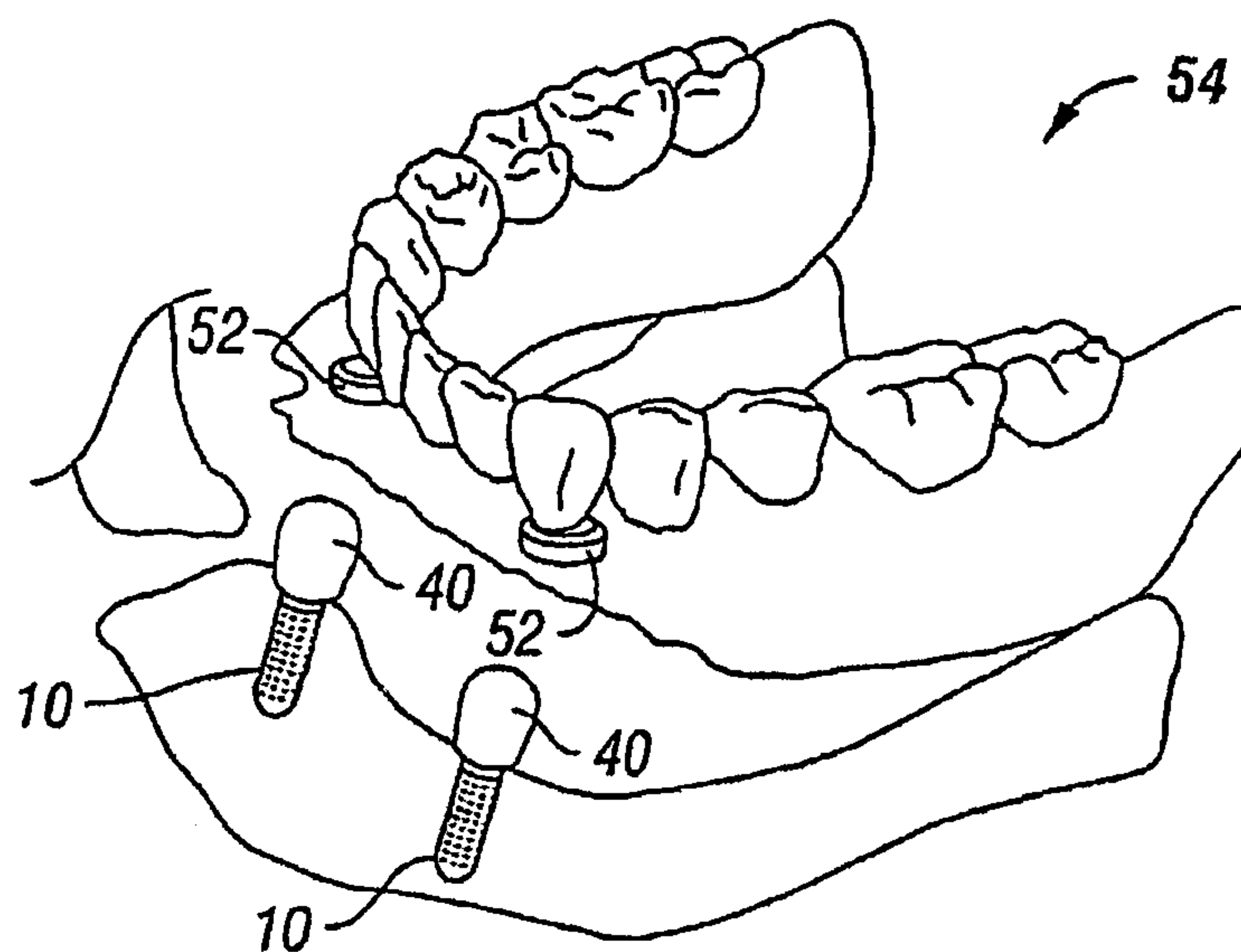


FIG. 6A

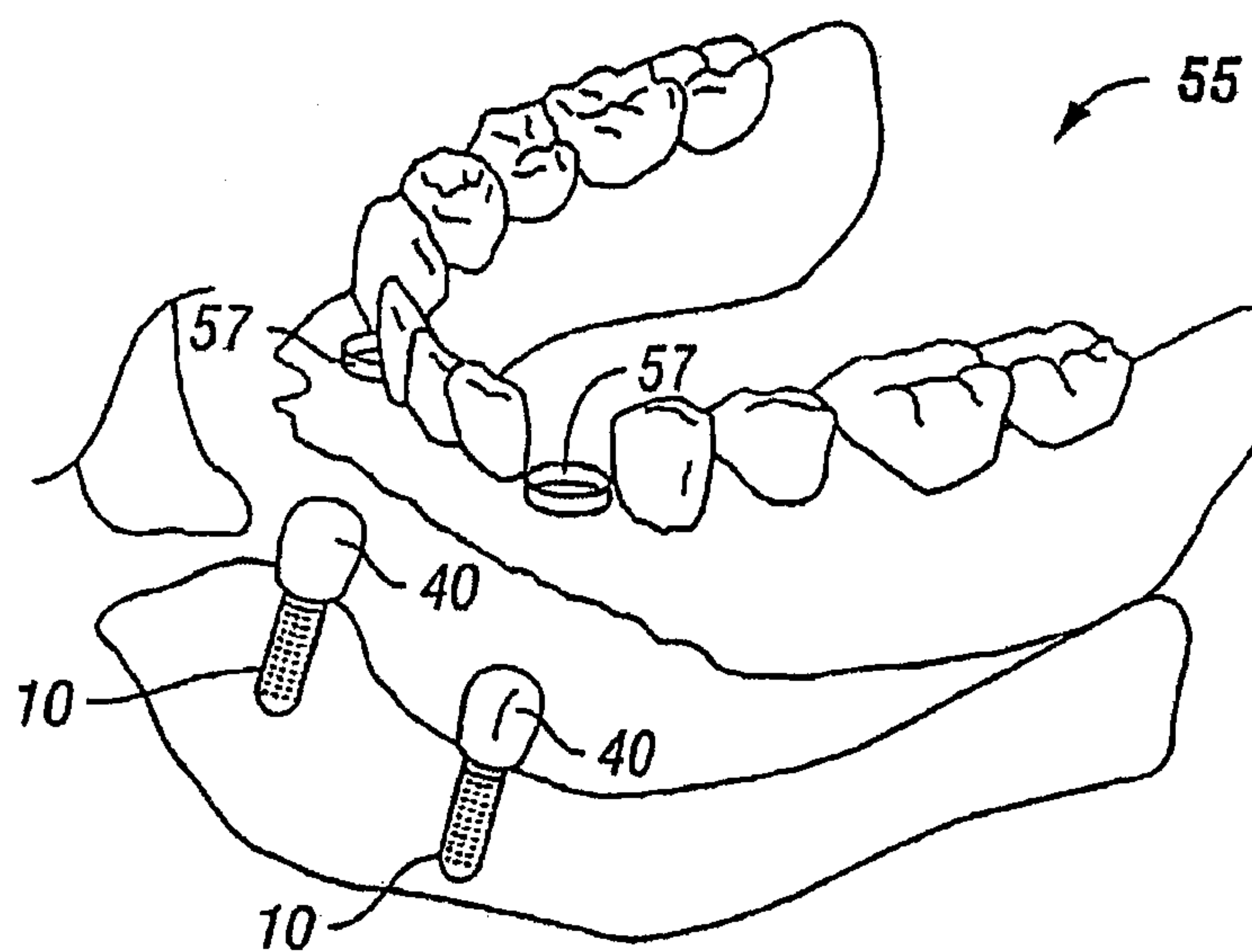


FIG. 6B



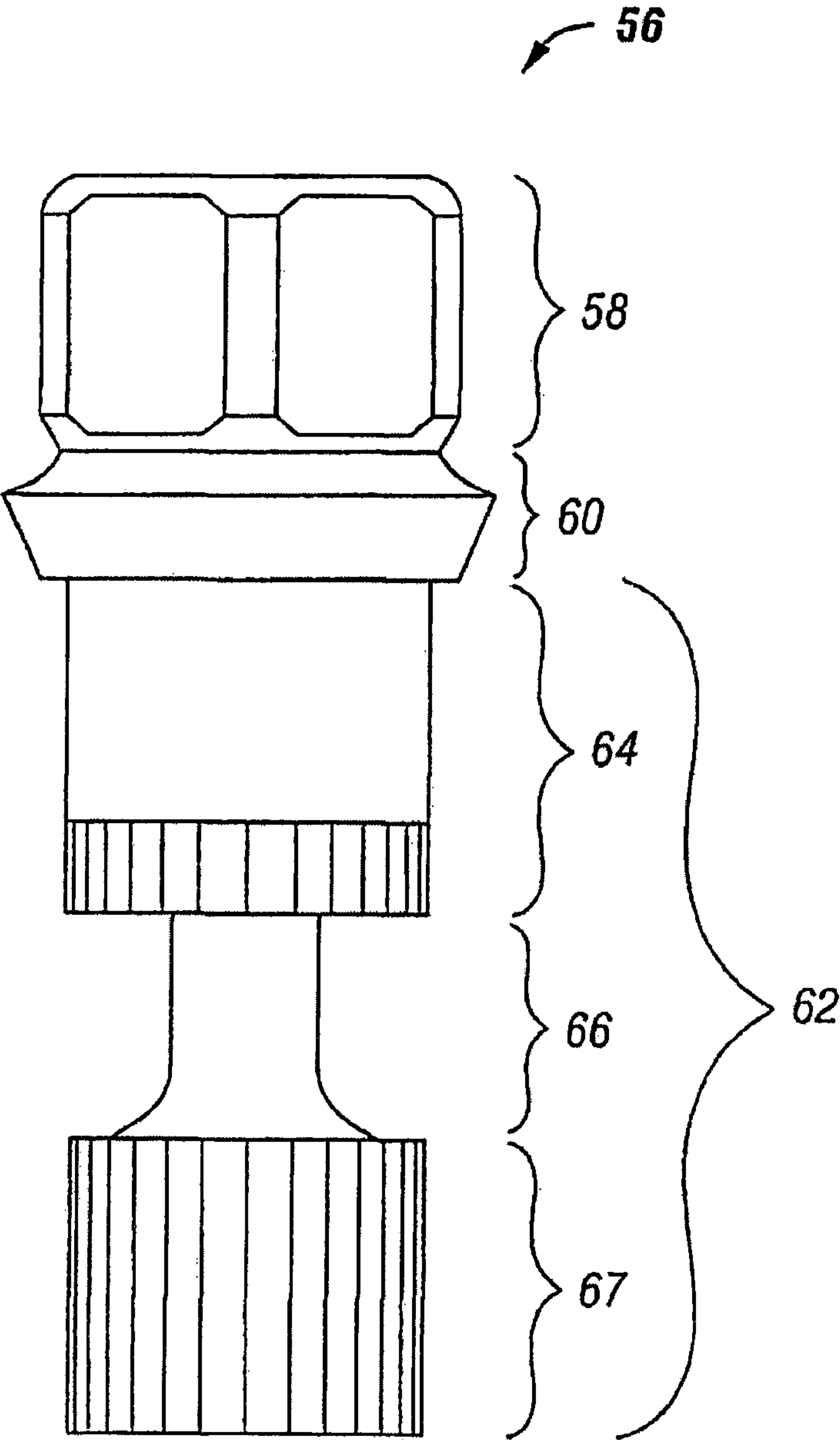
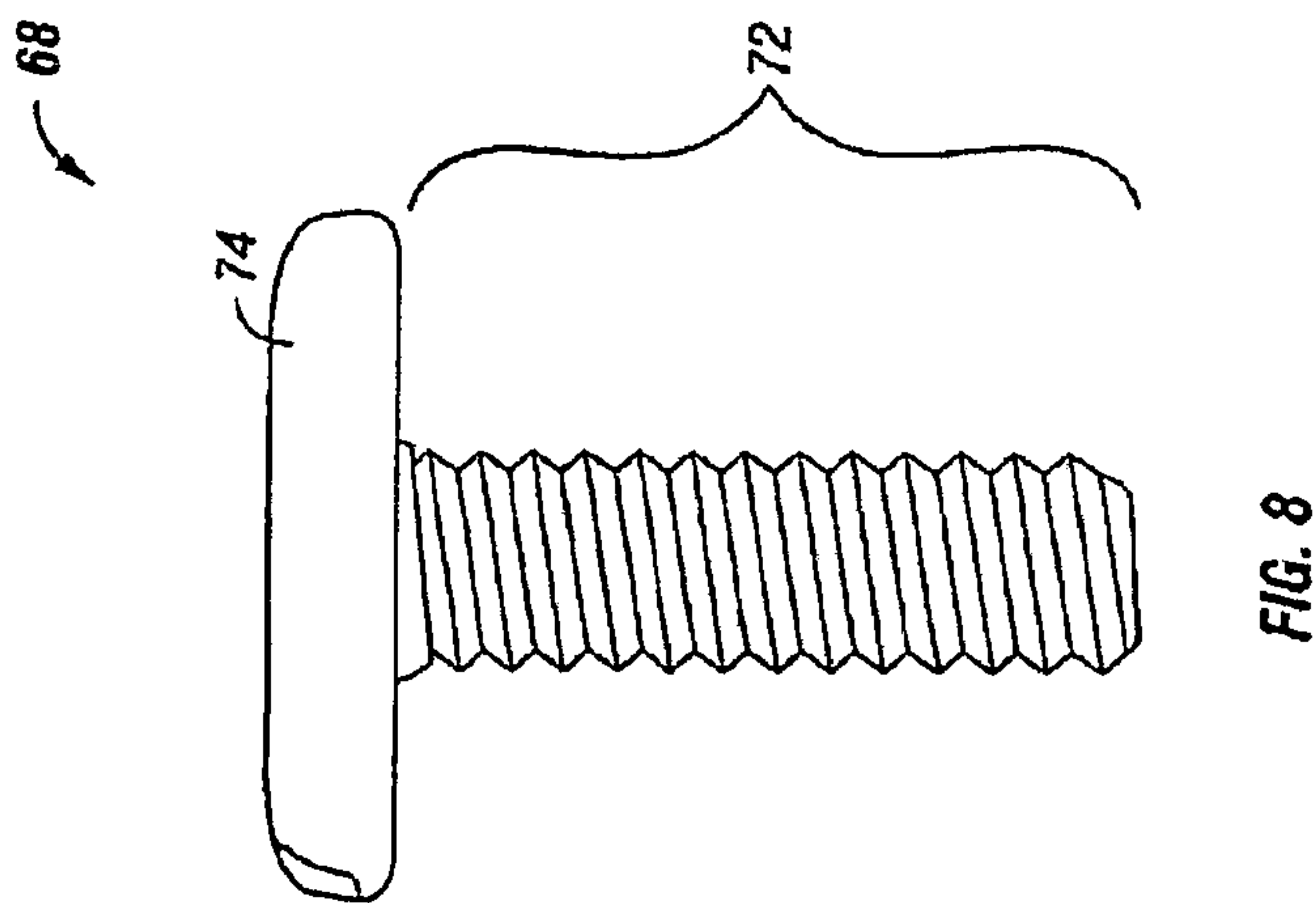
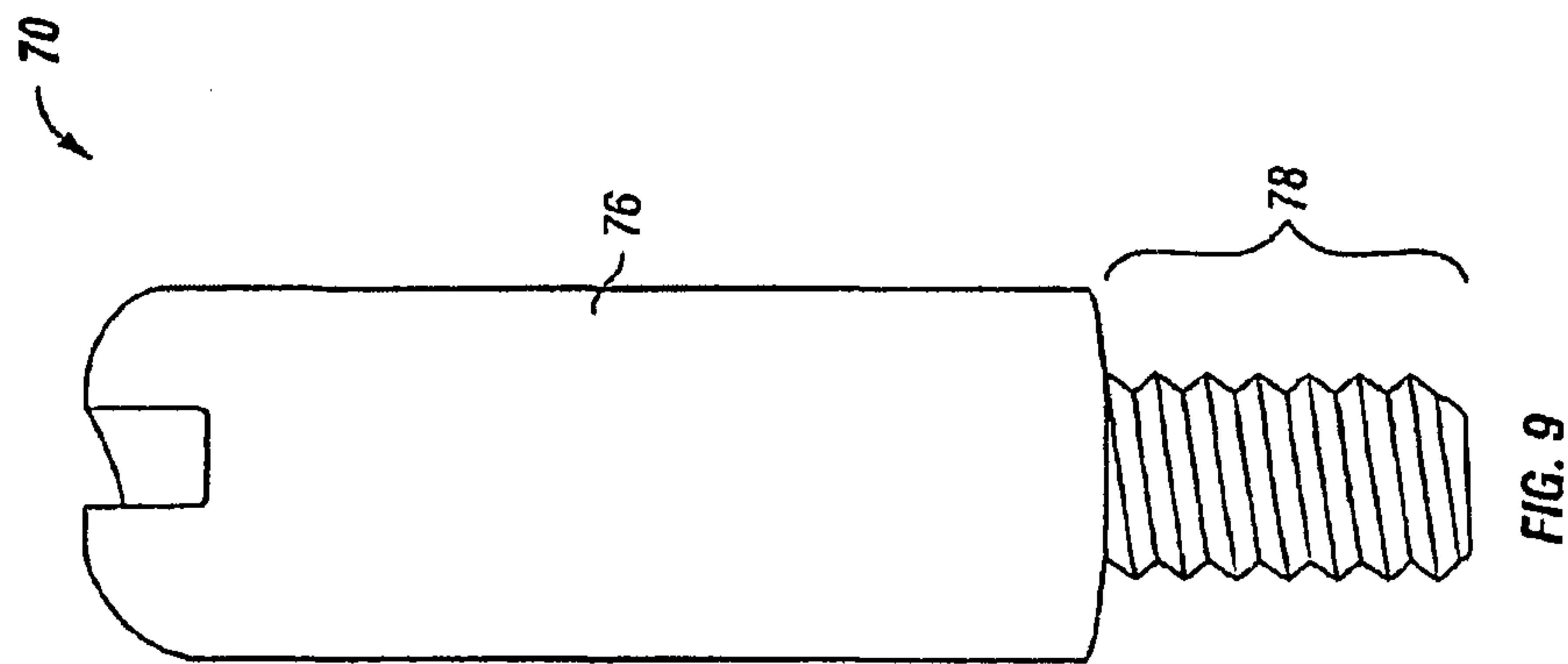
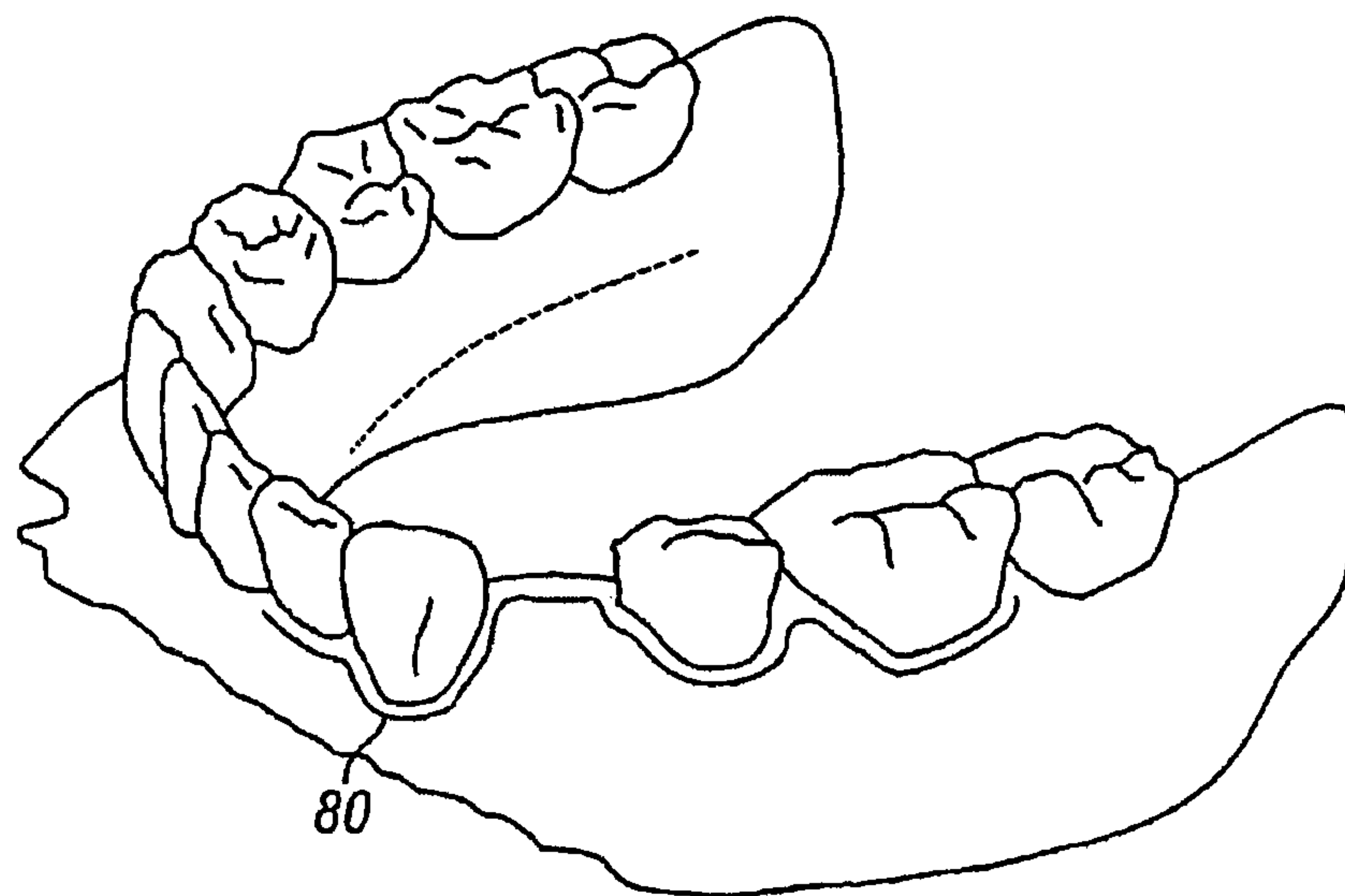
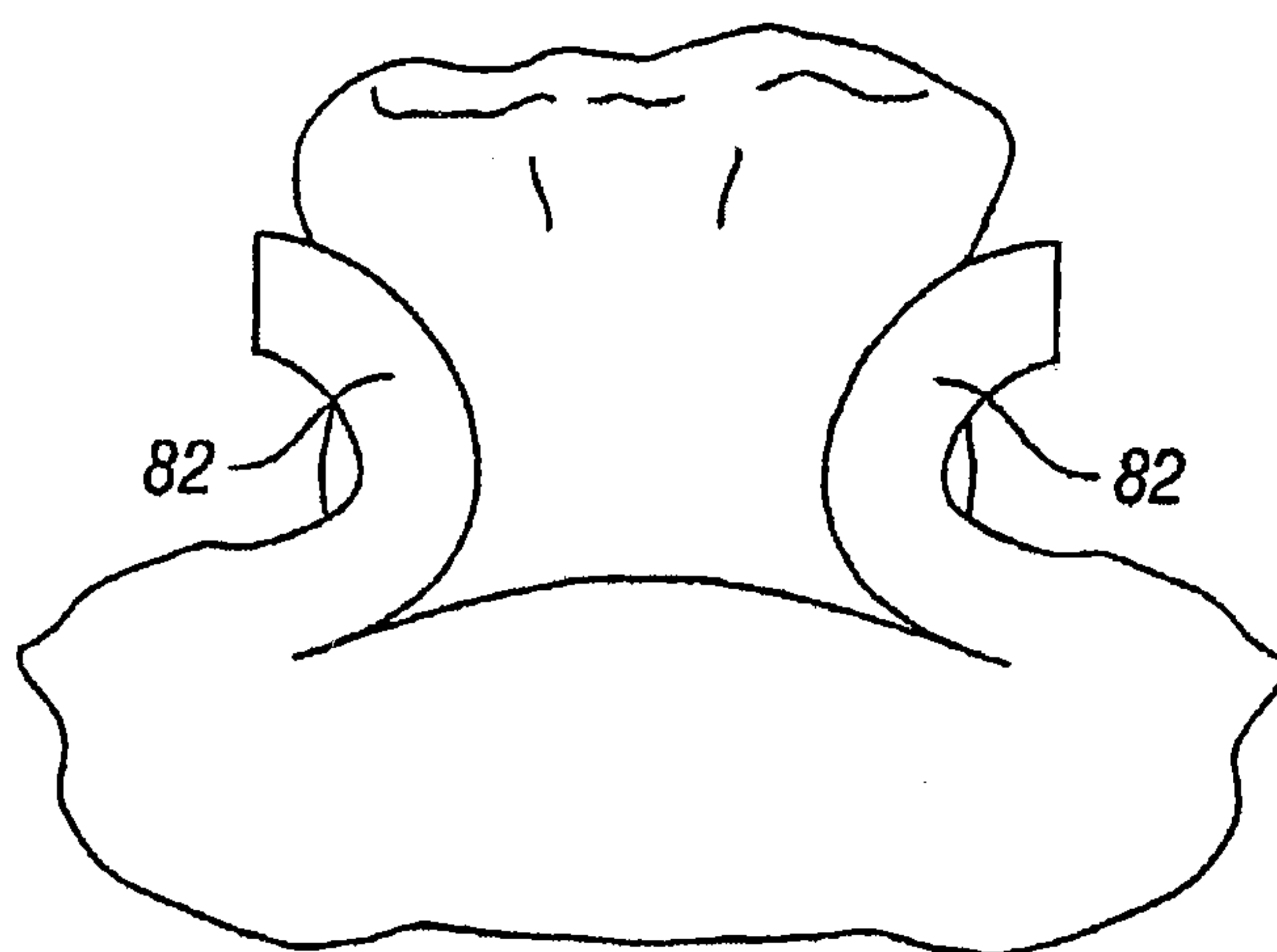


FIG. 7





**FIG. 10**



**FIG. 11**

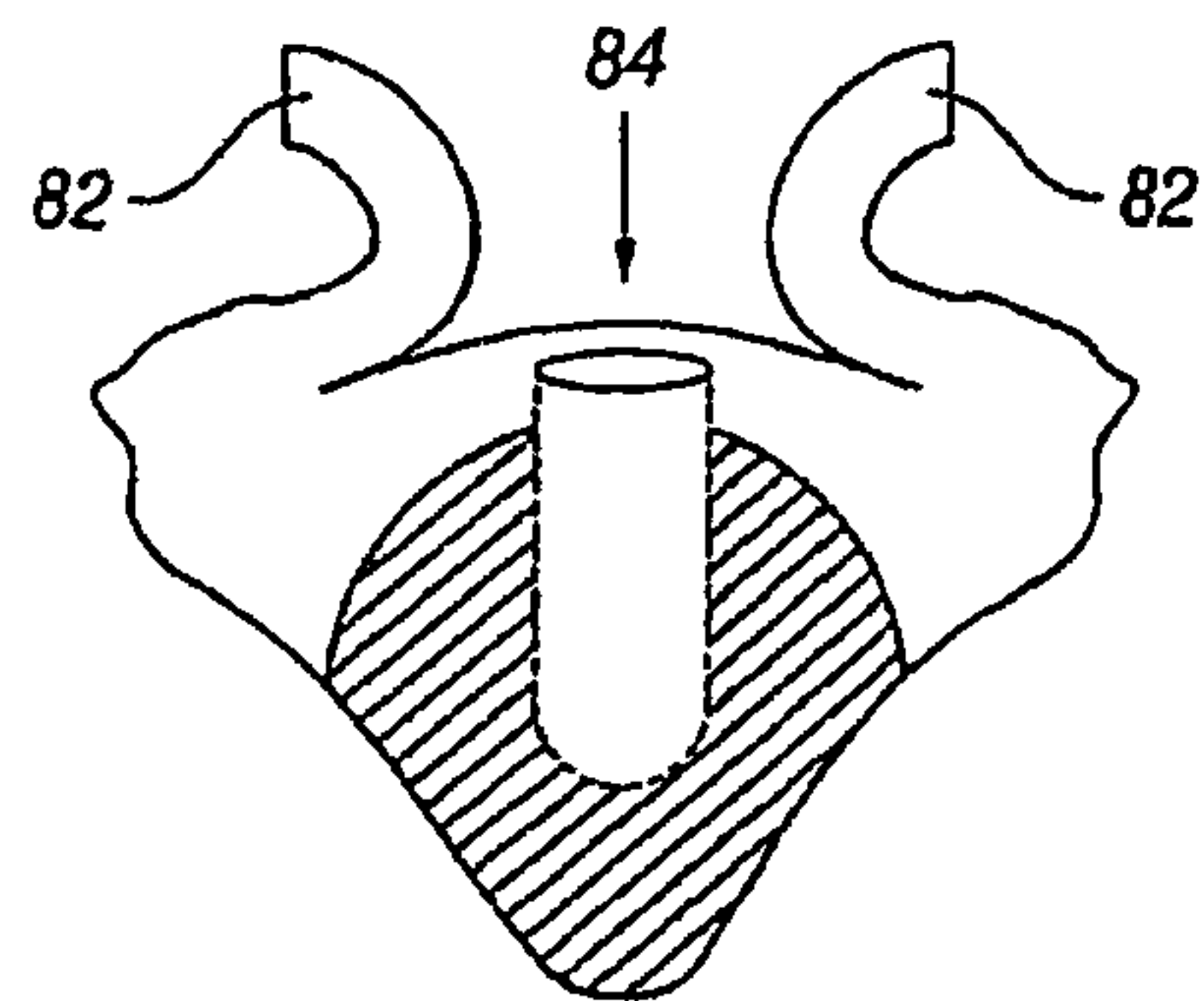


FIG. 12

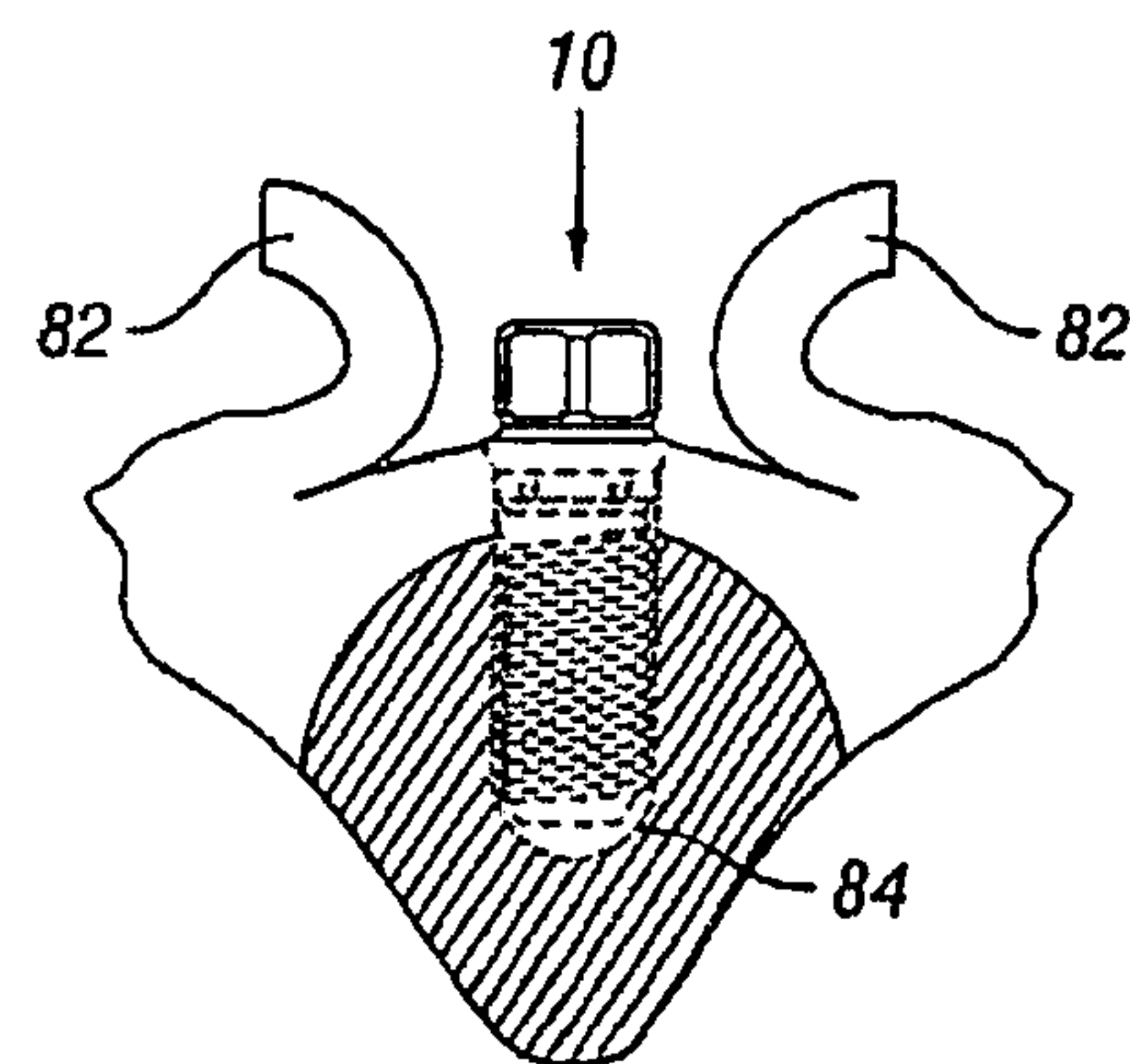


FIG. 13

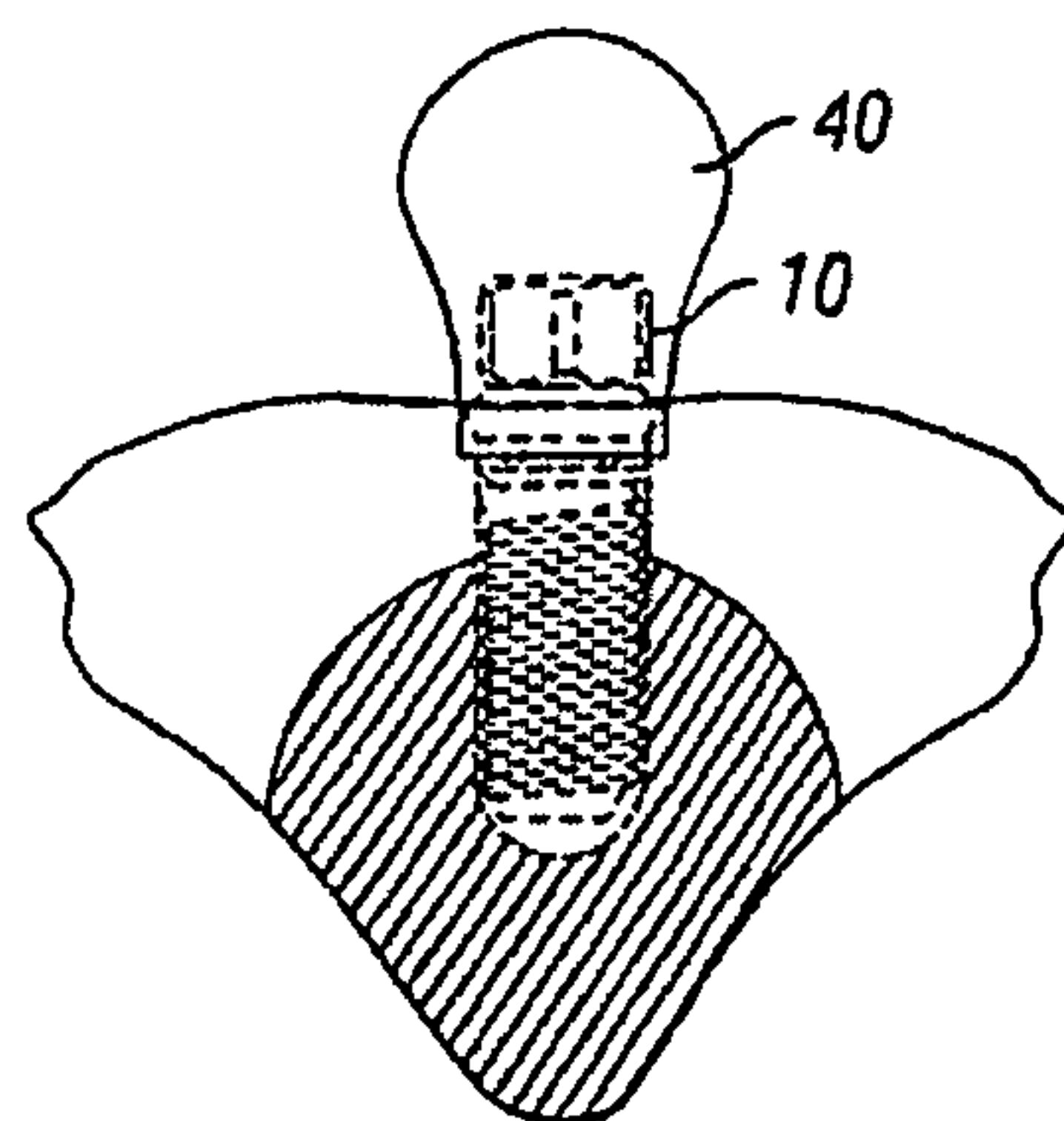


FIG. 14

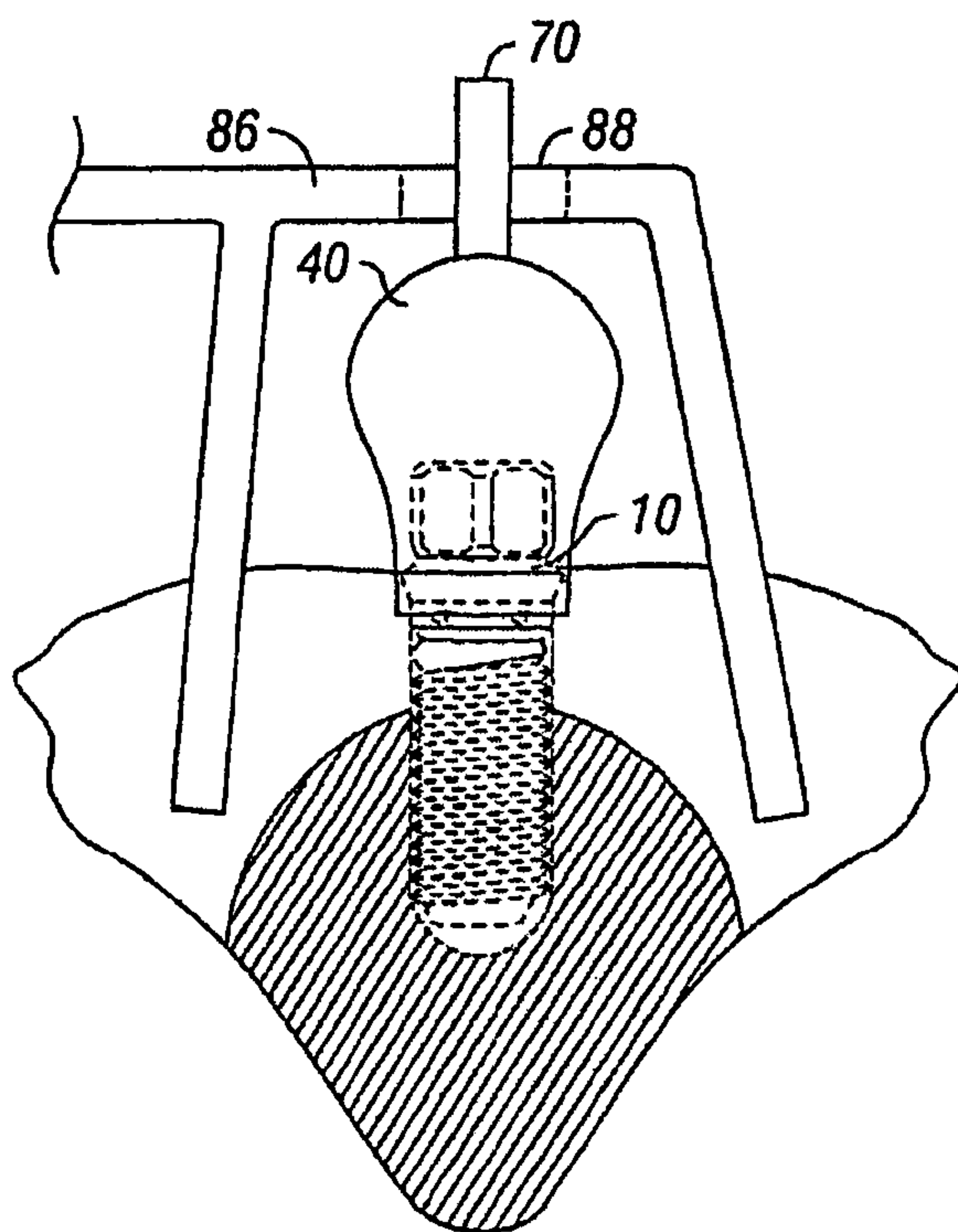


FIG. 15

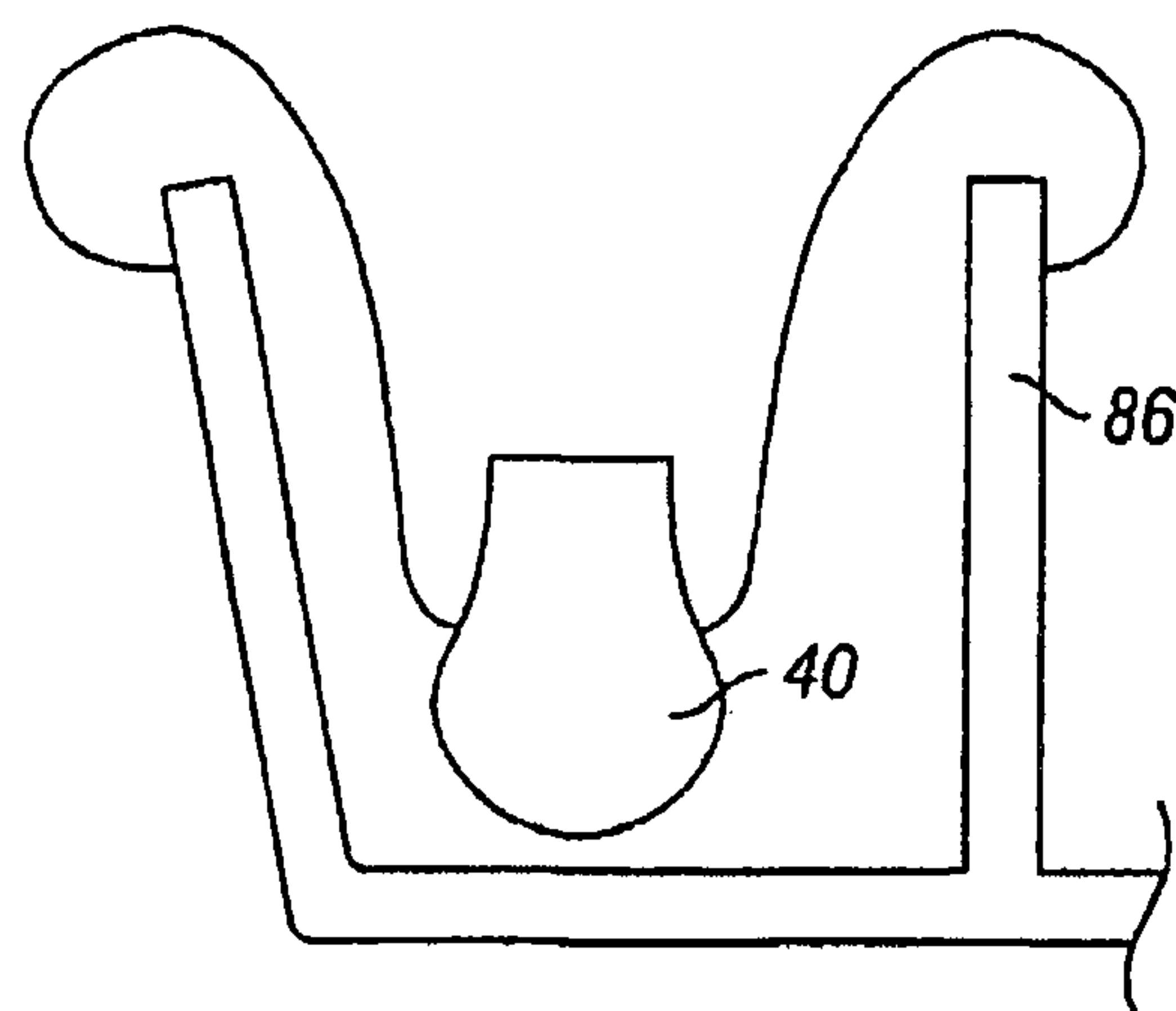


FIG. 16

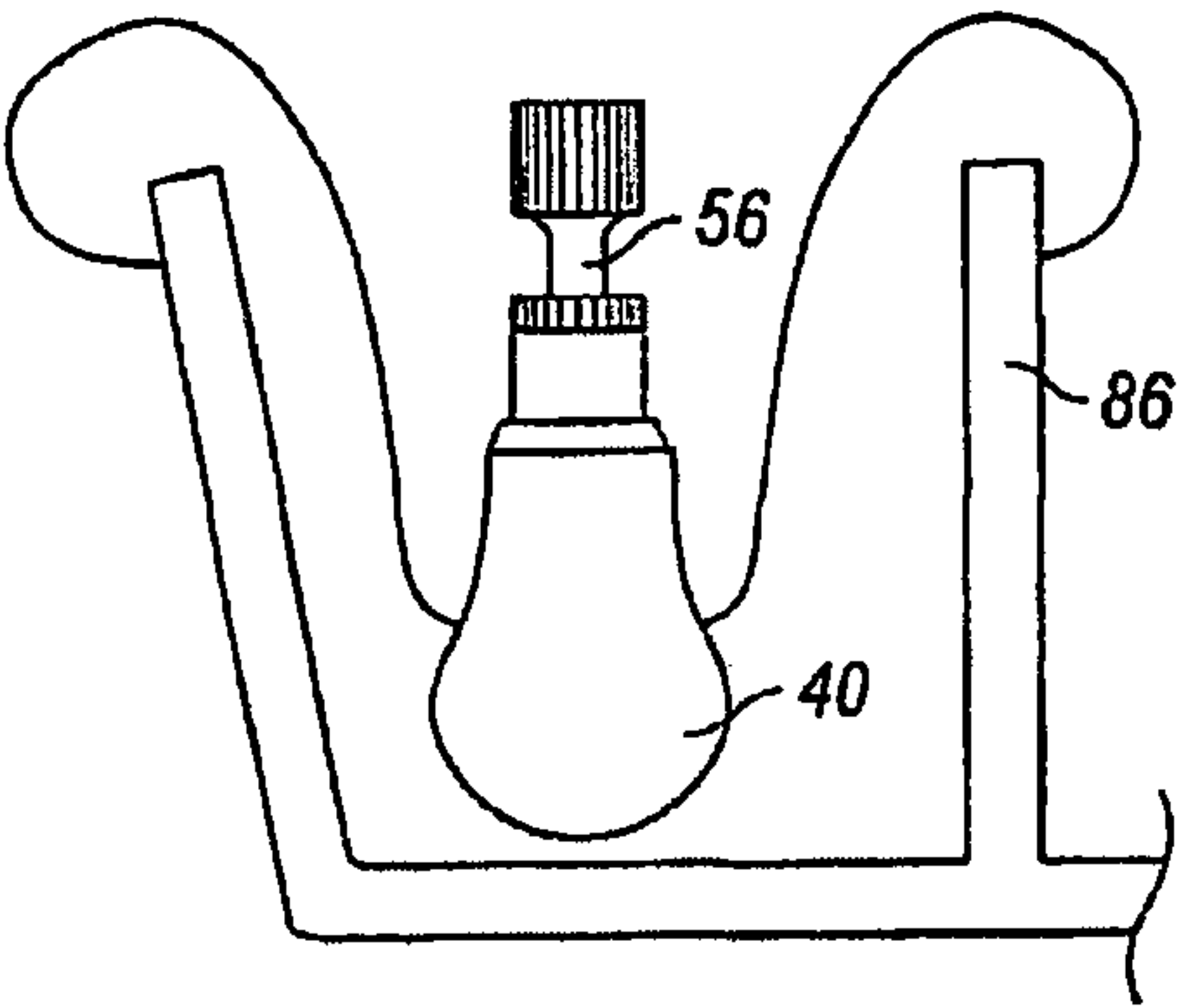


FIG. 17

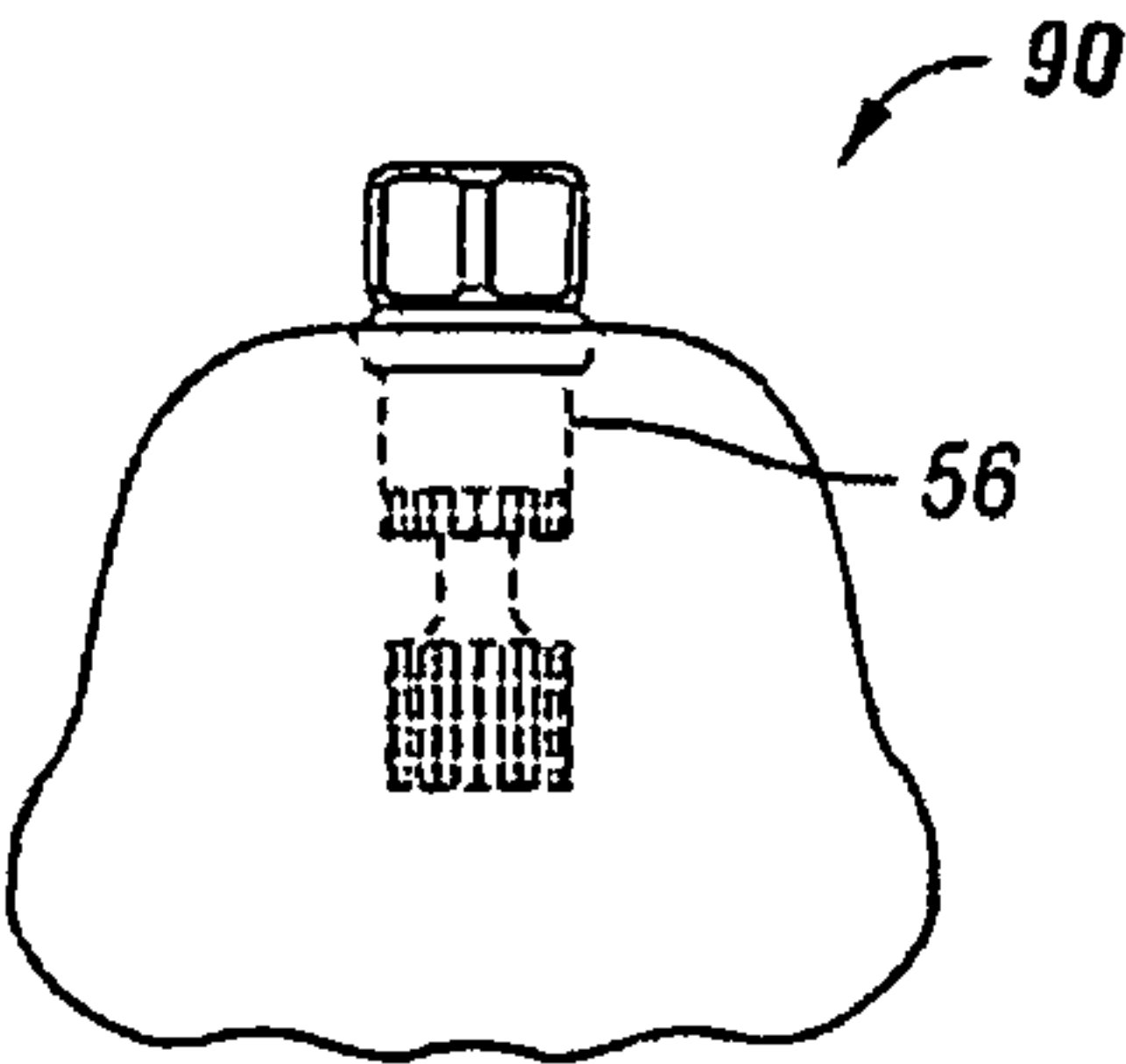


FIG. 18

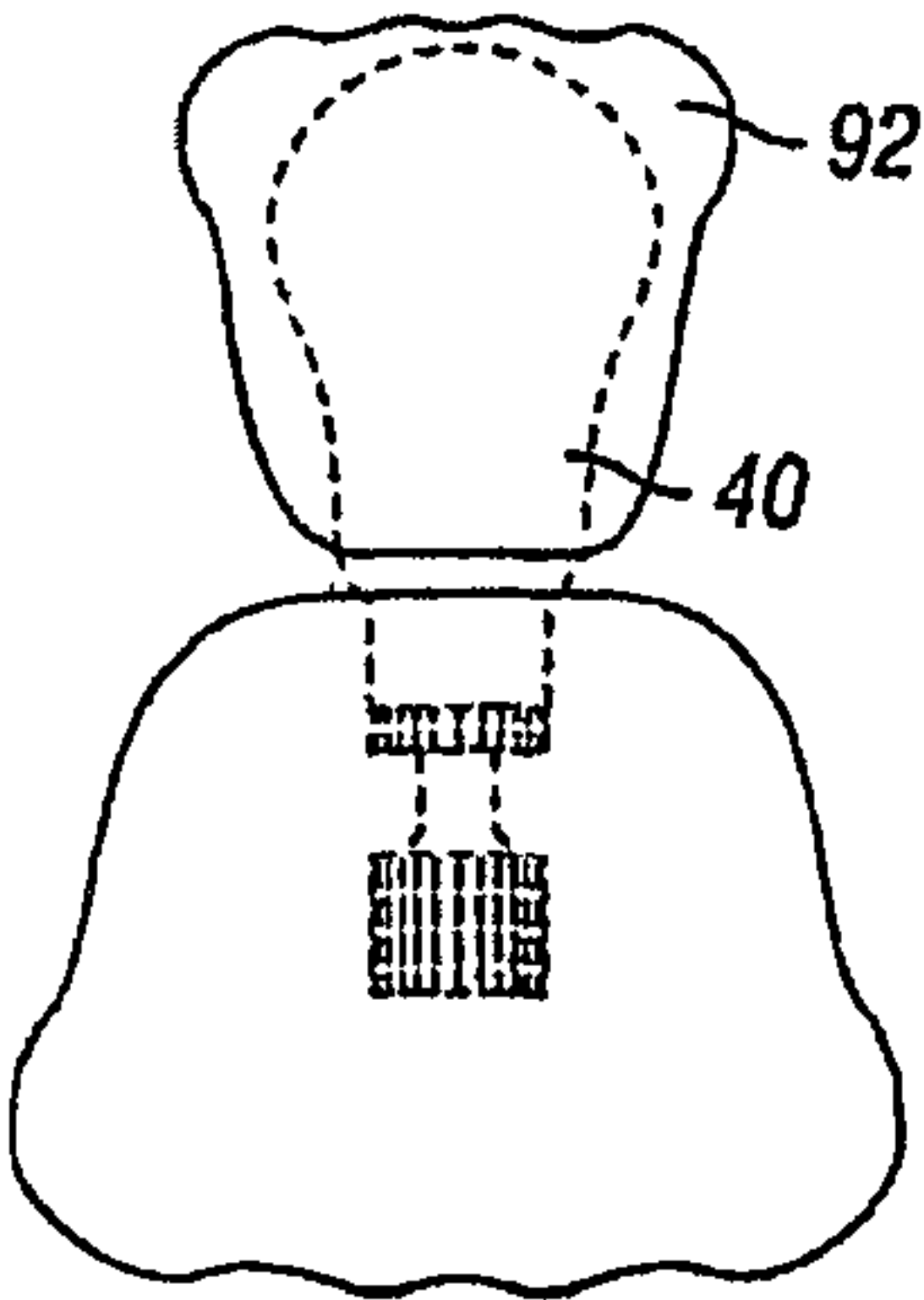


FIG. 19



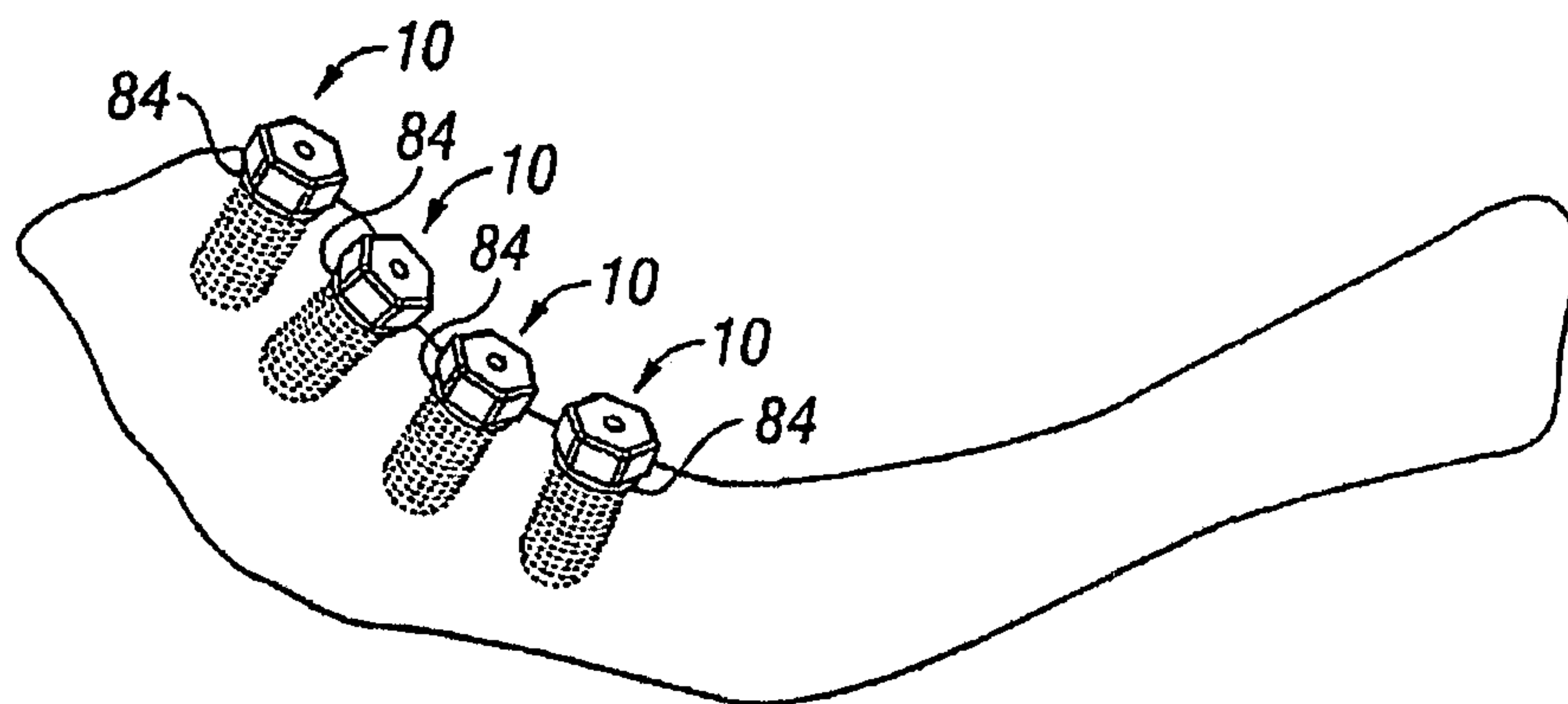


FIG. 20

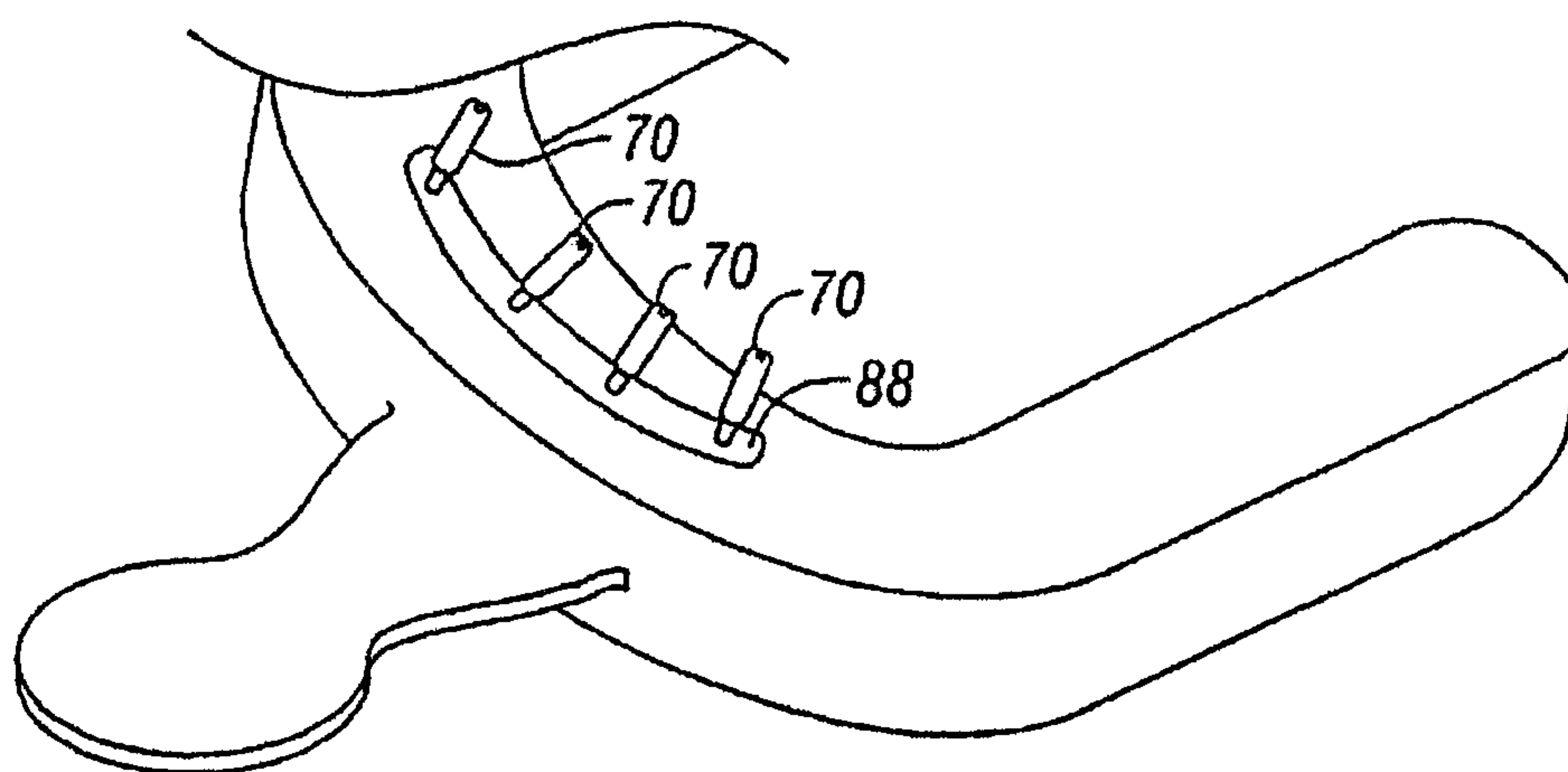


FIG. 21

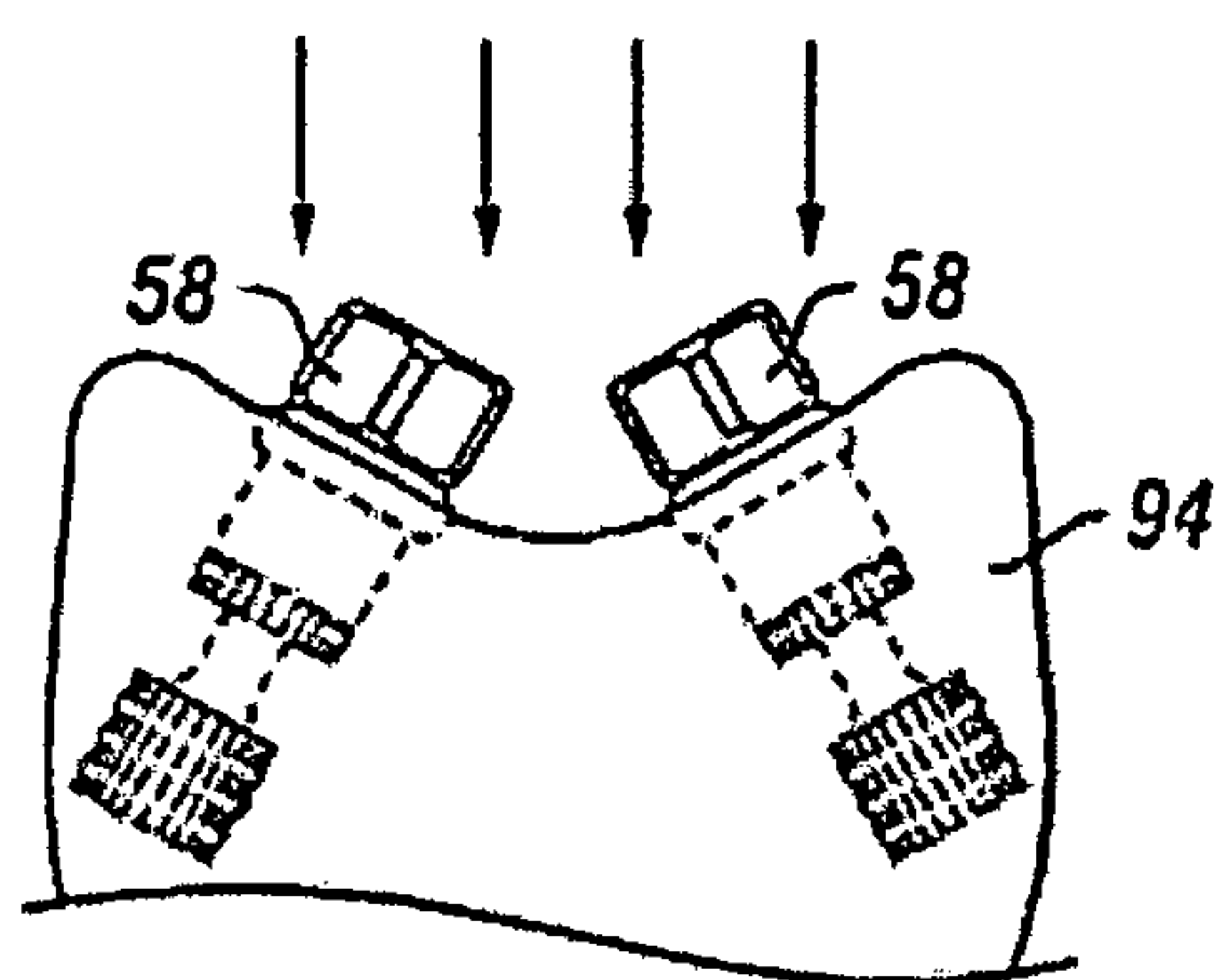


FIG. 22

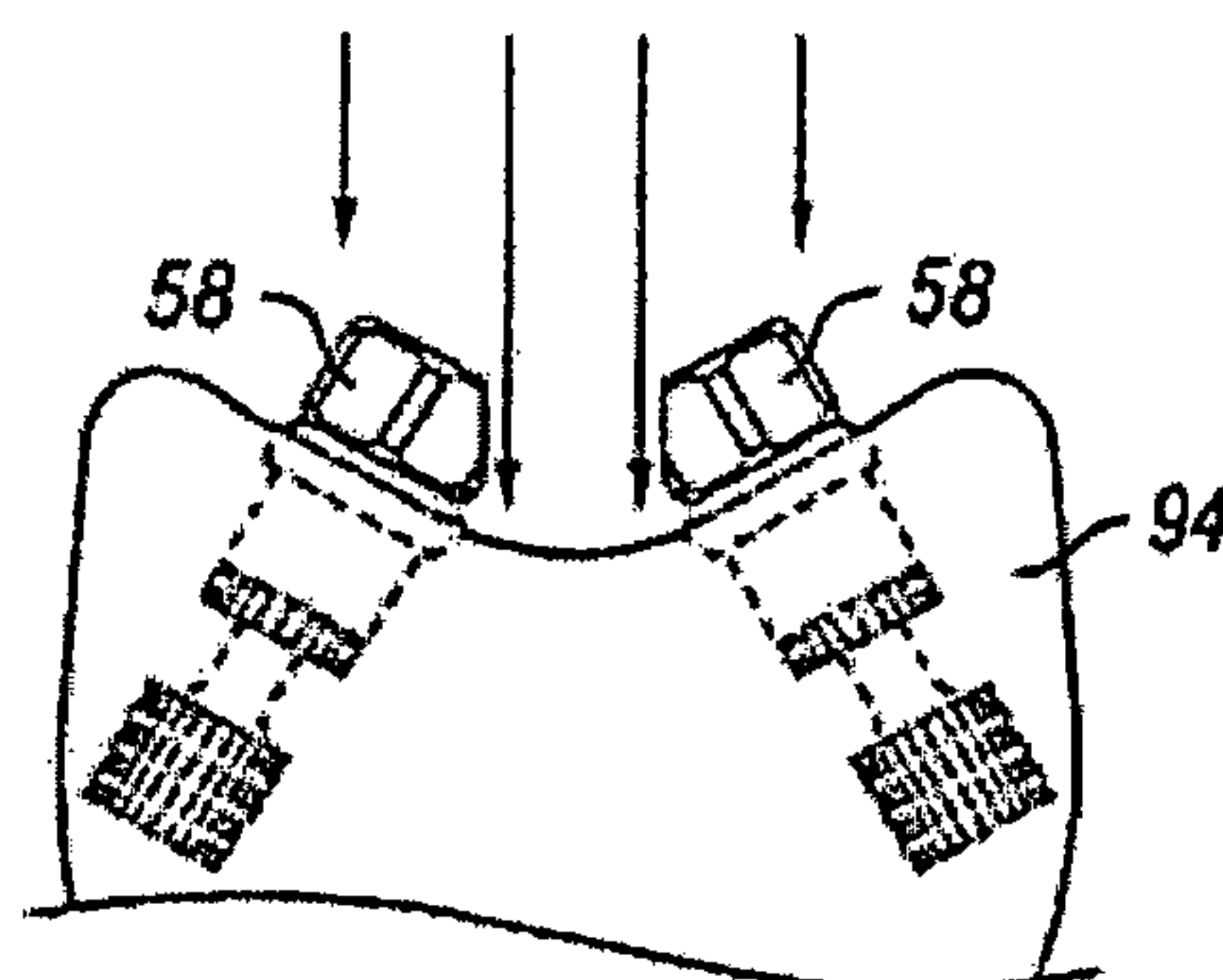


FIG. 23

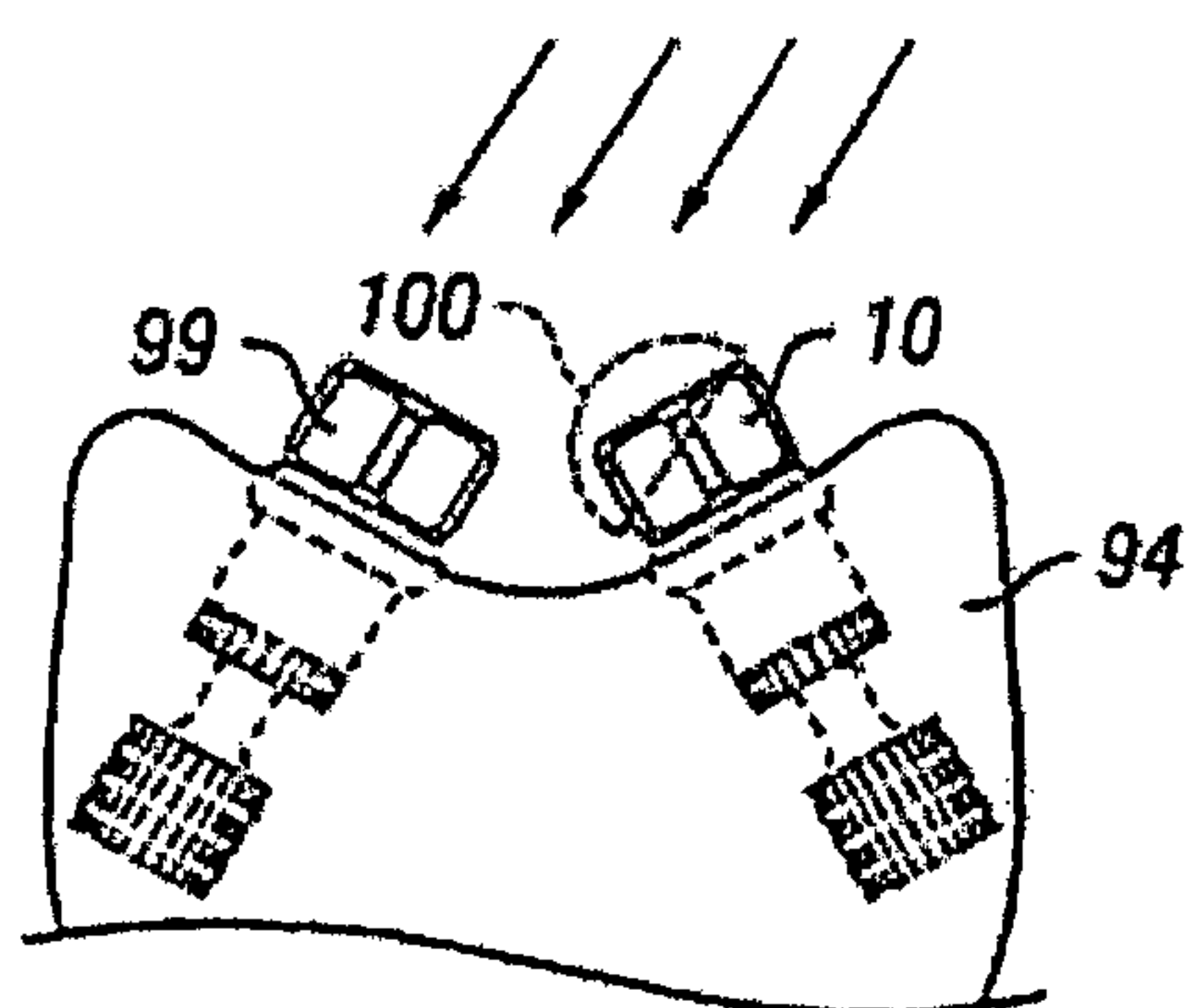


FIG. 24

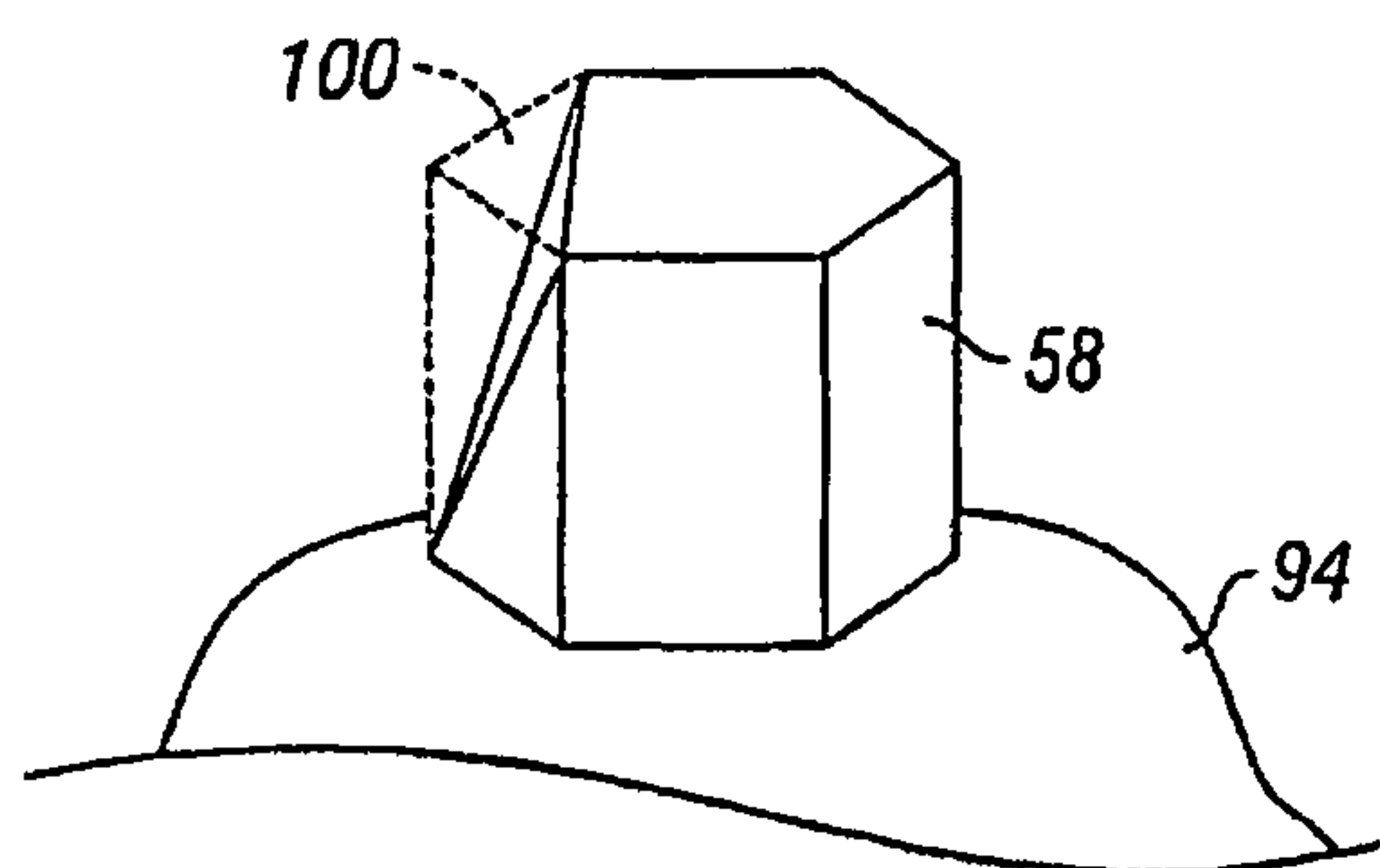


FIG. 25

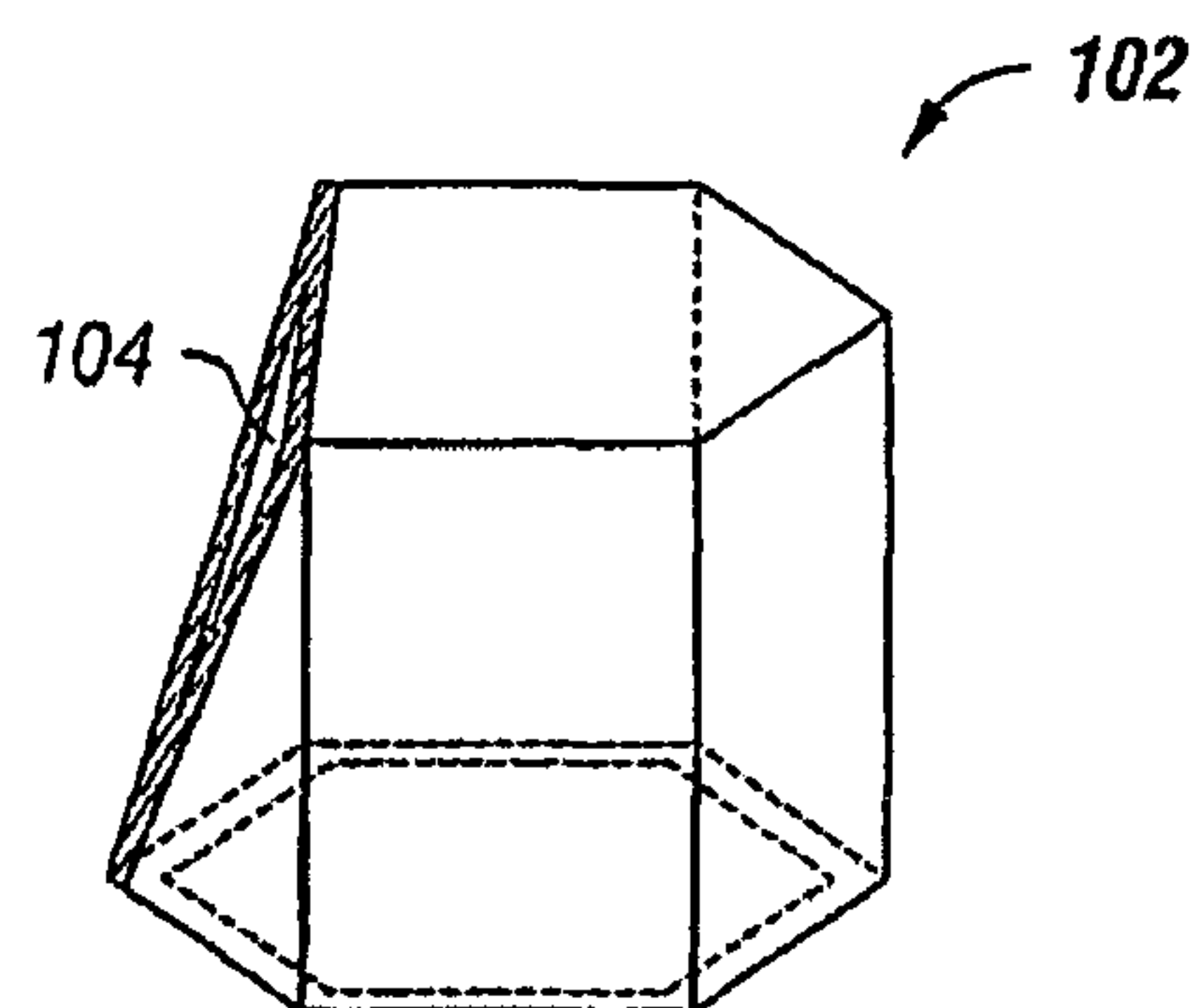


FIG. 26

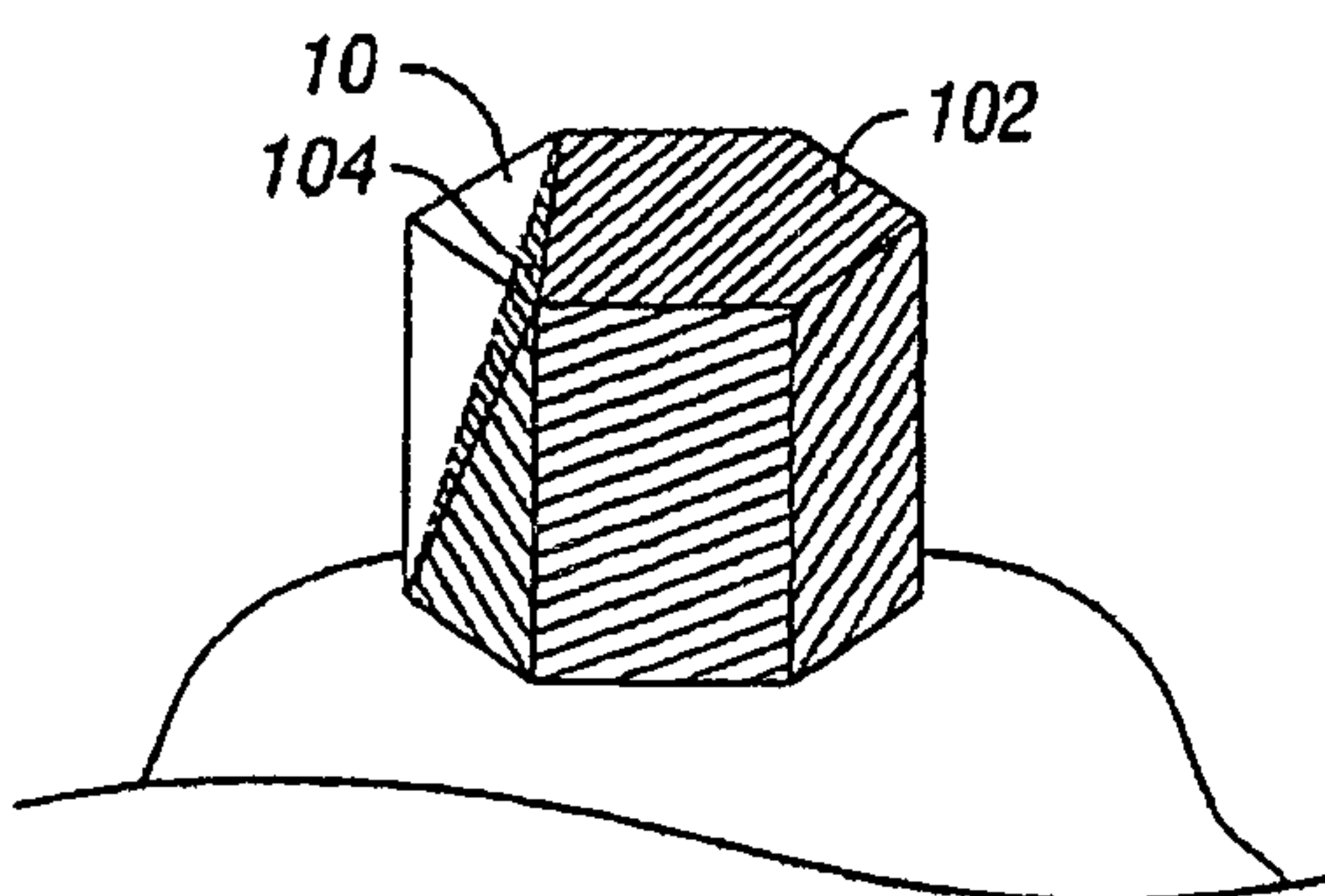
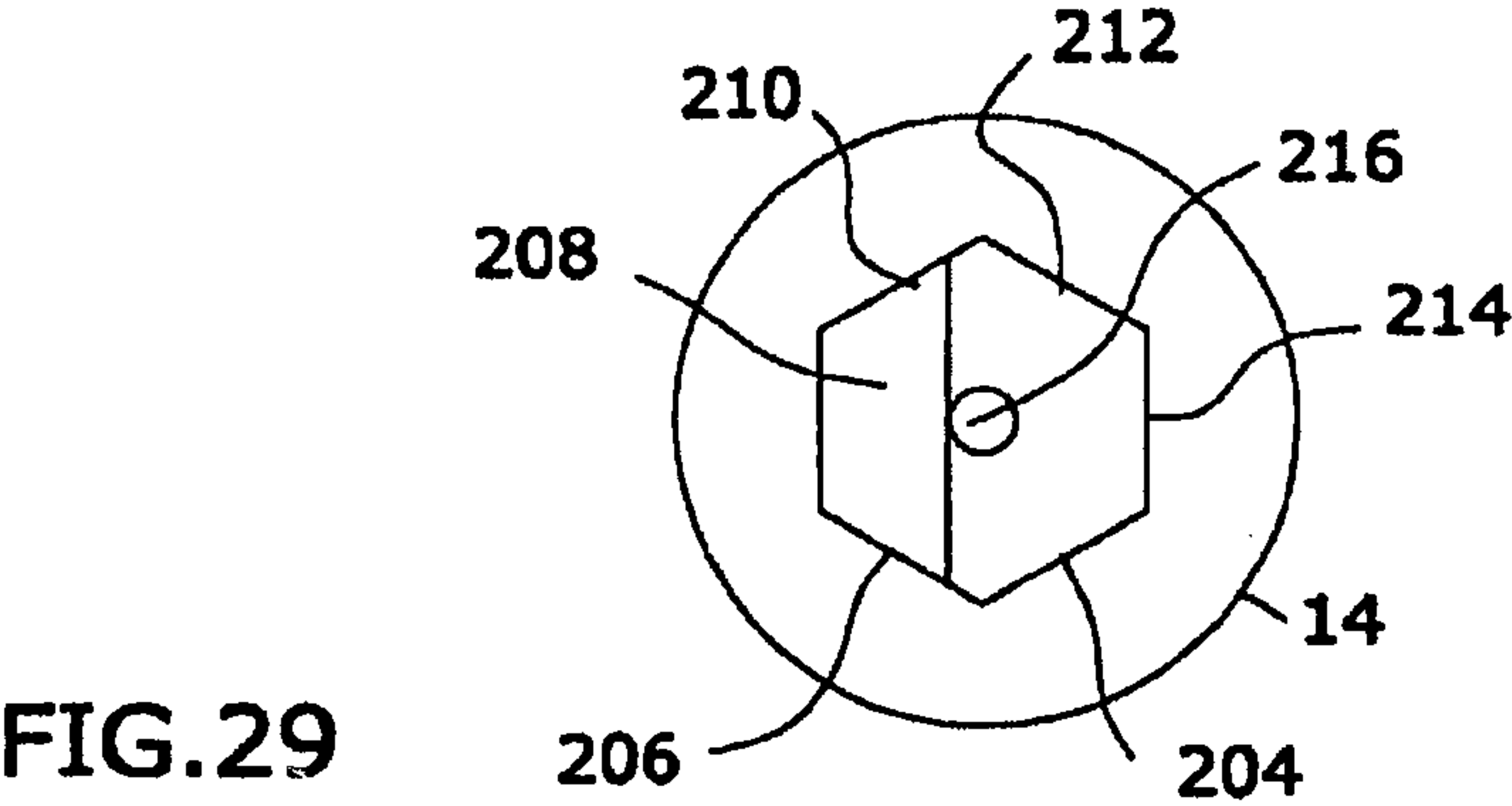
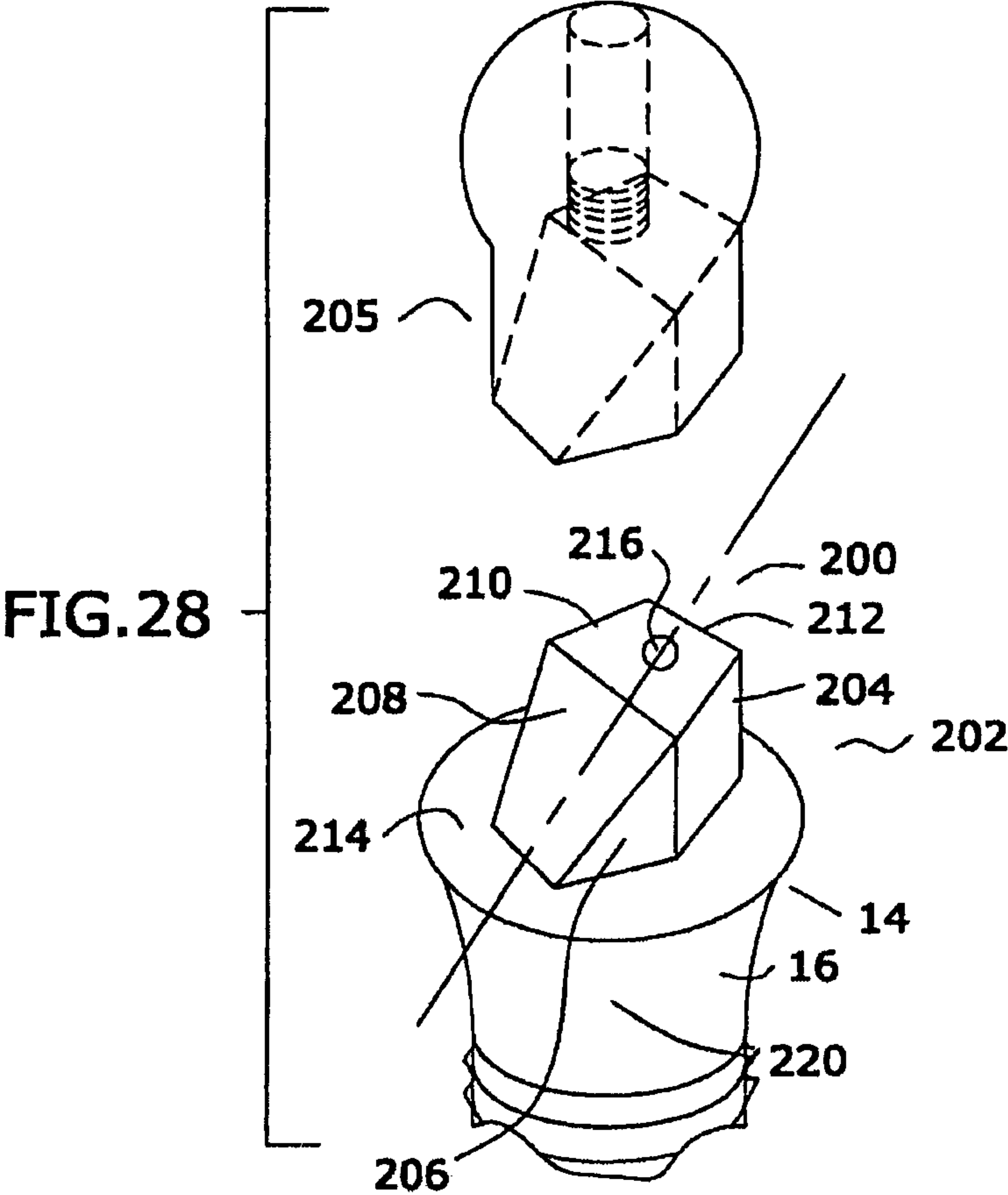


FIG. 27



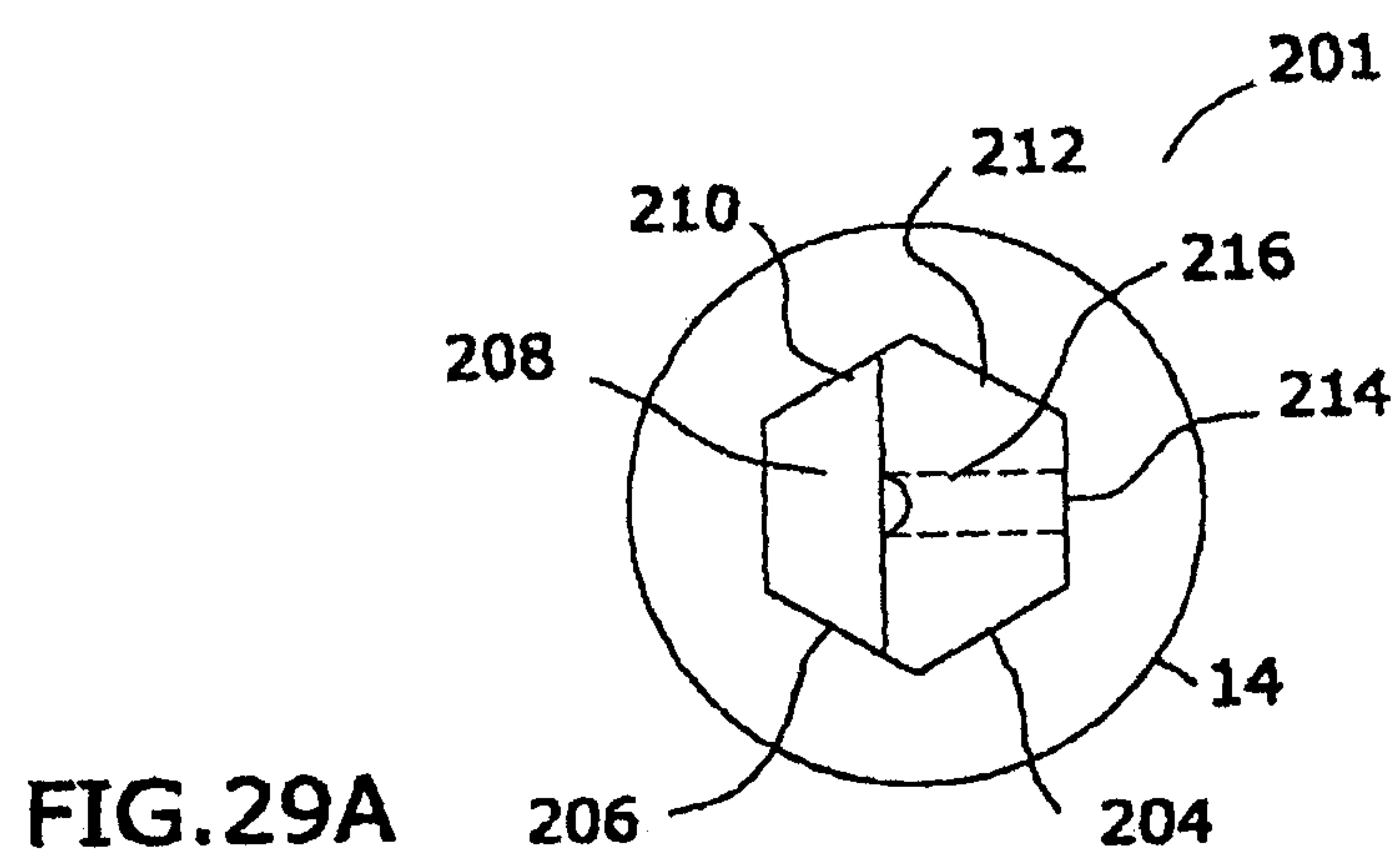
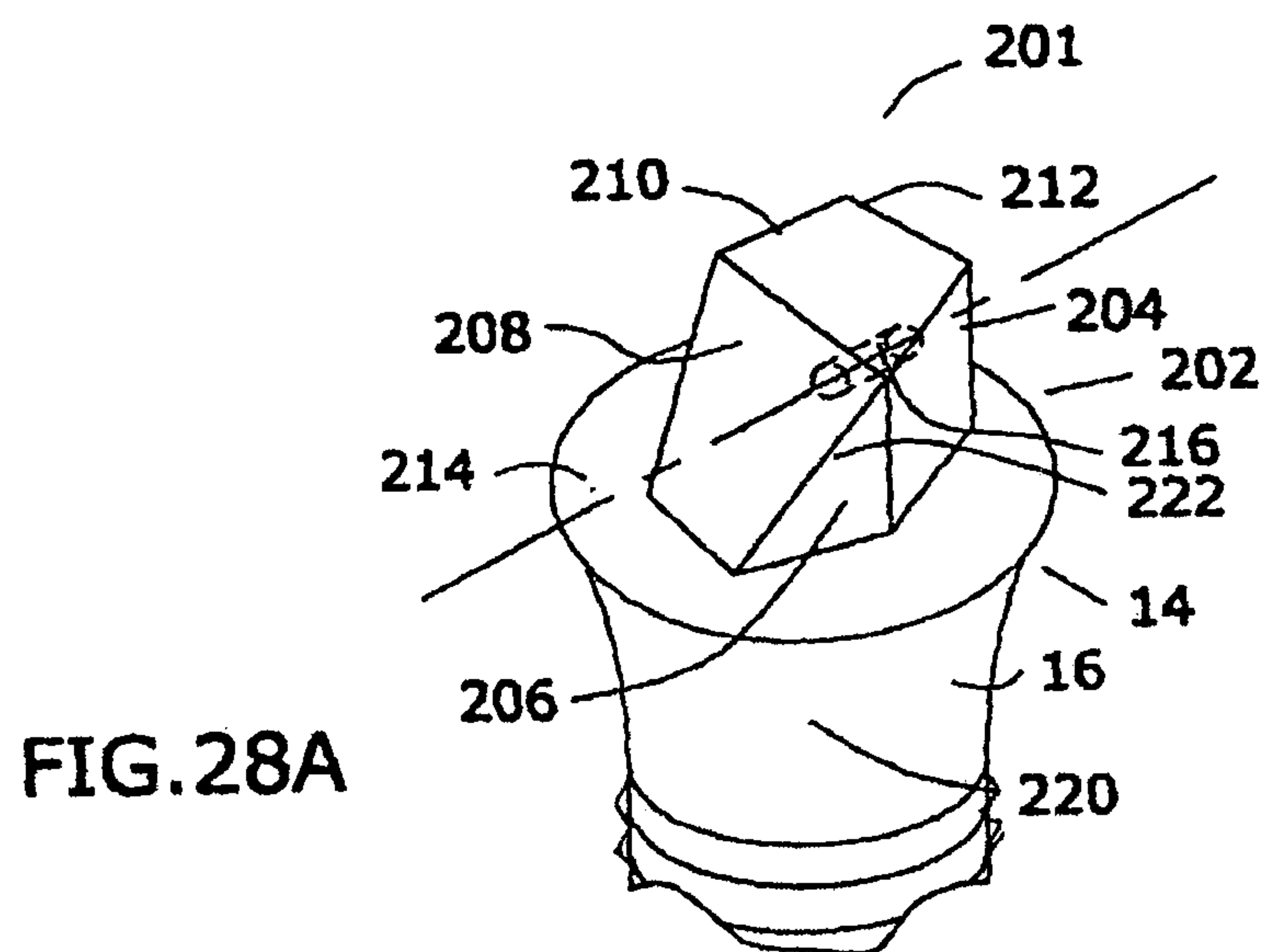


FIG.28B

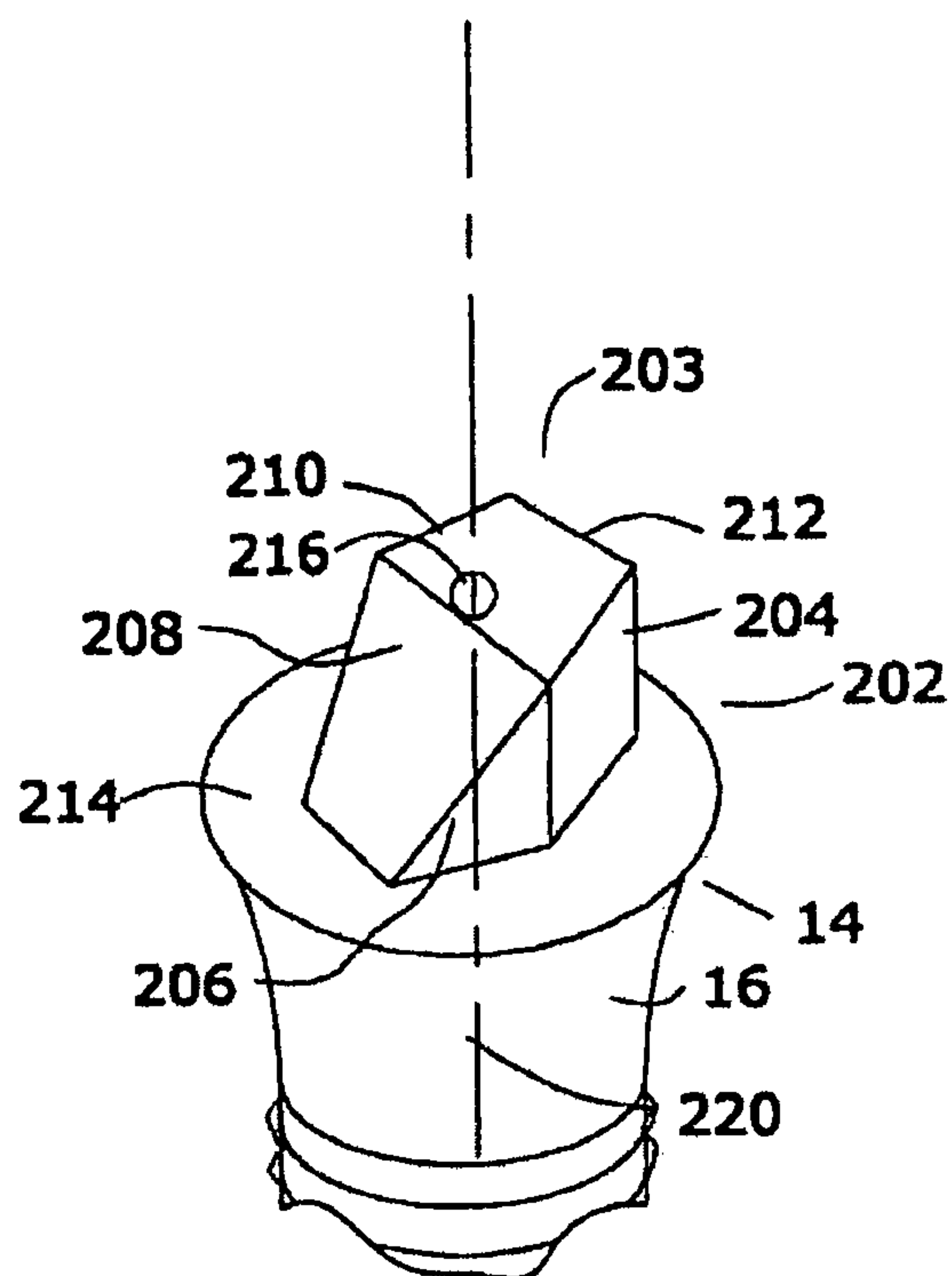
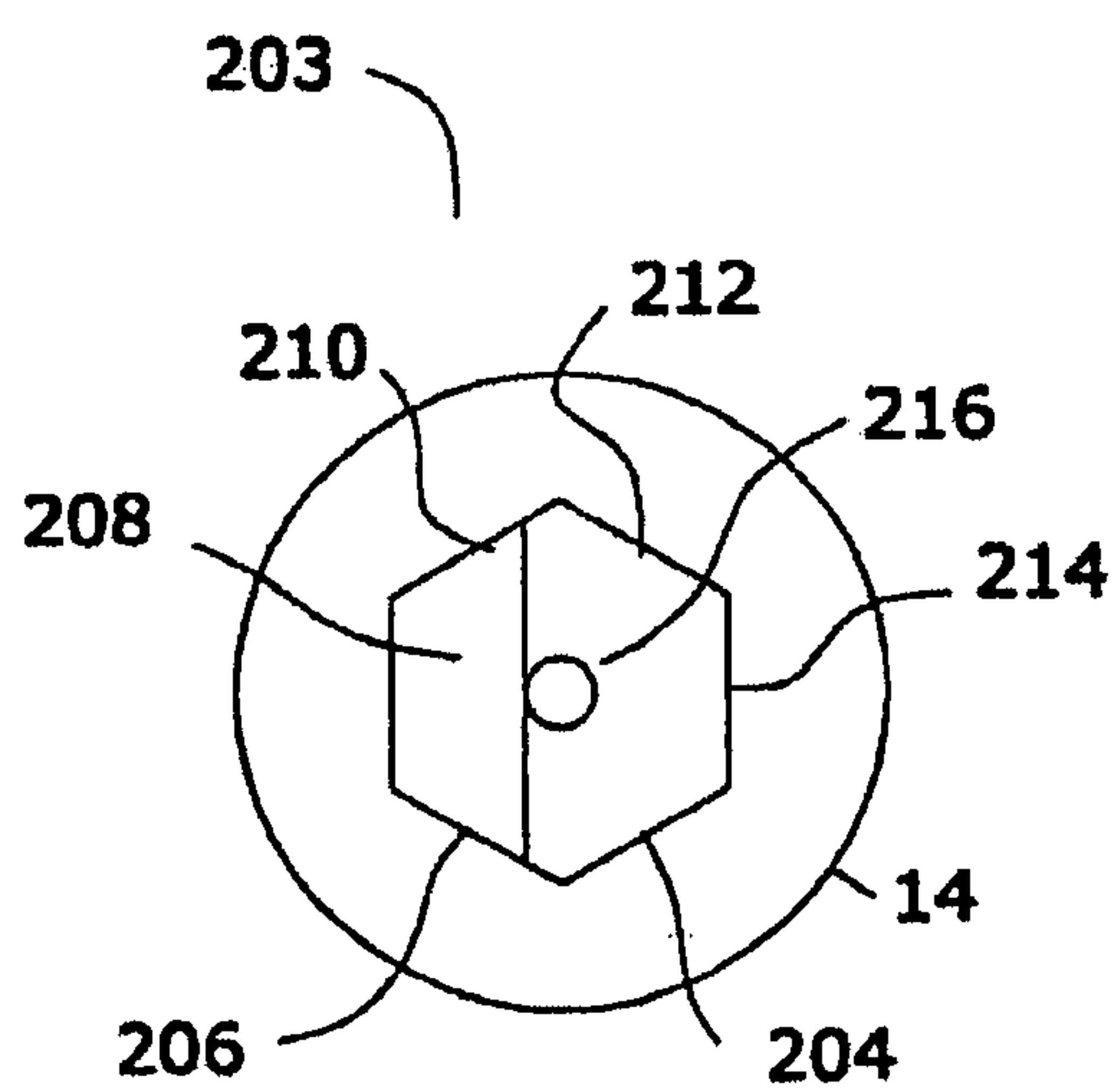
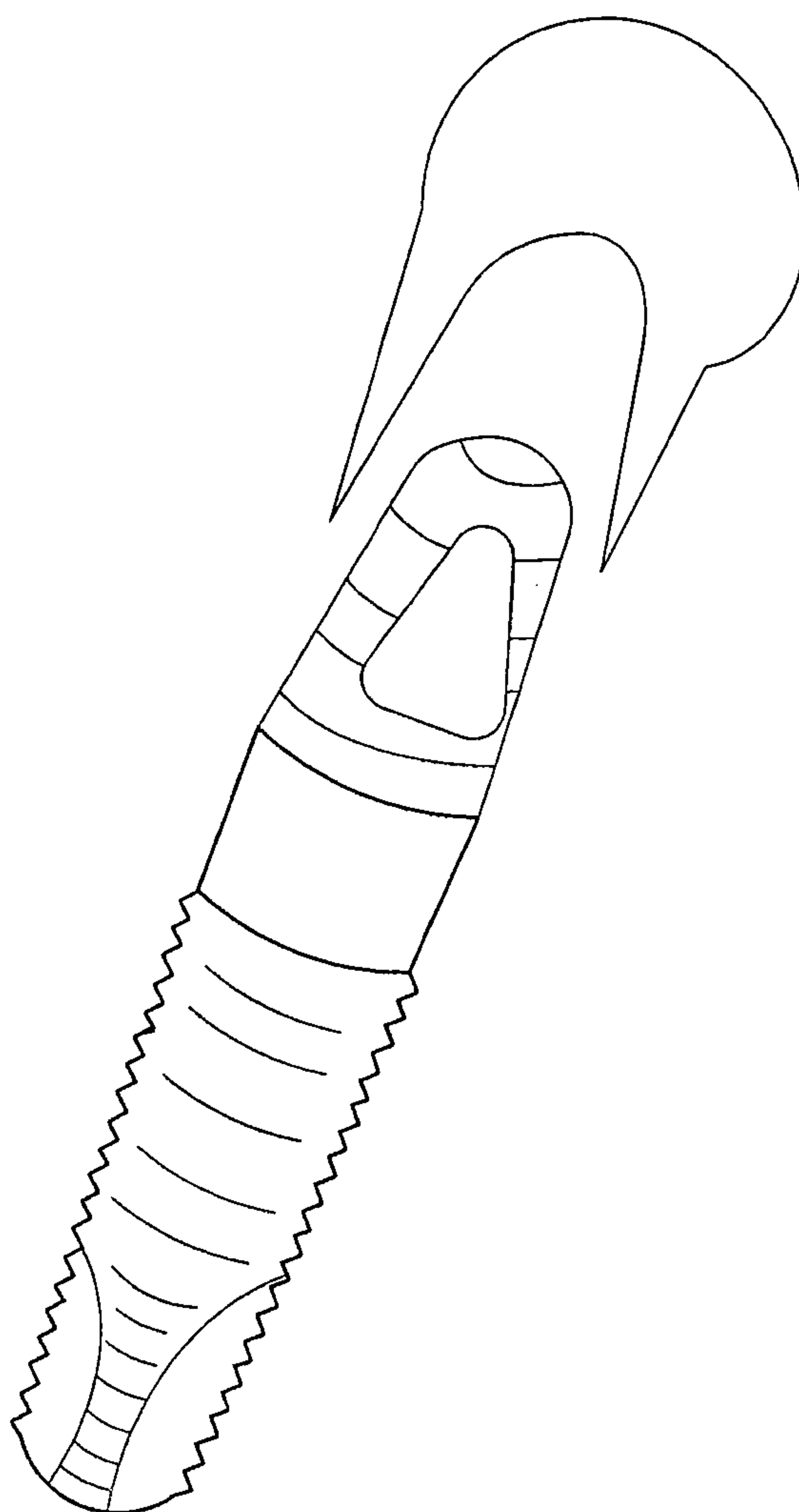


FIG.29B







**FIG. 28C**

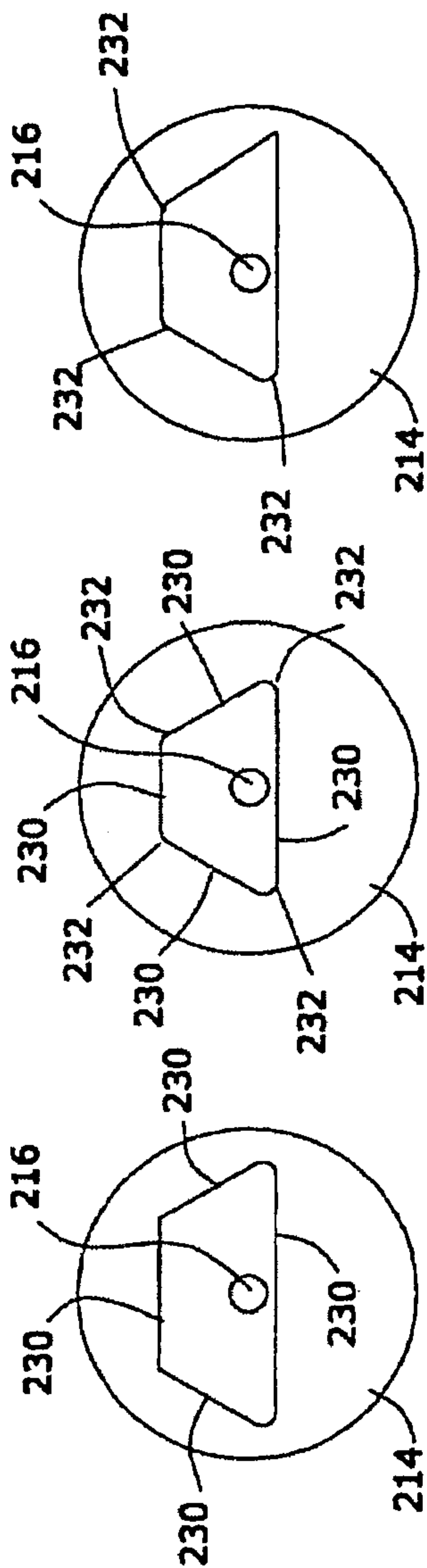


FIG. 30A

FIG. 30B

FIG. 30C

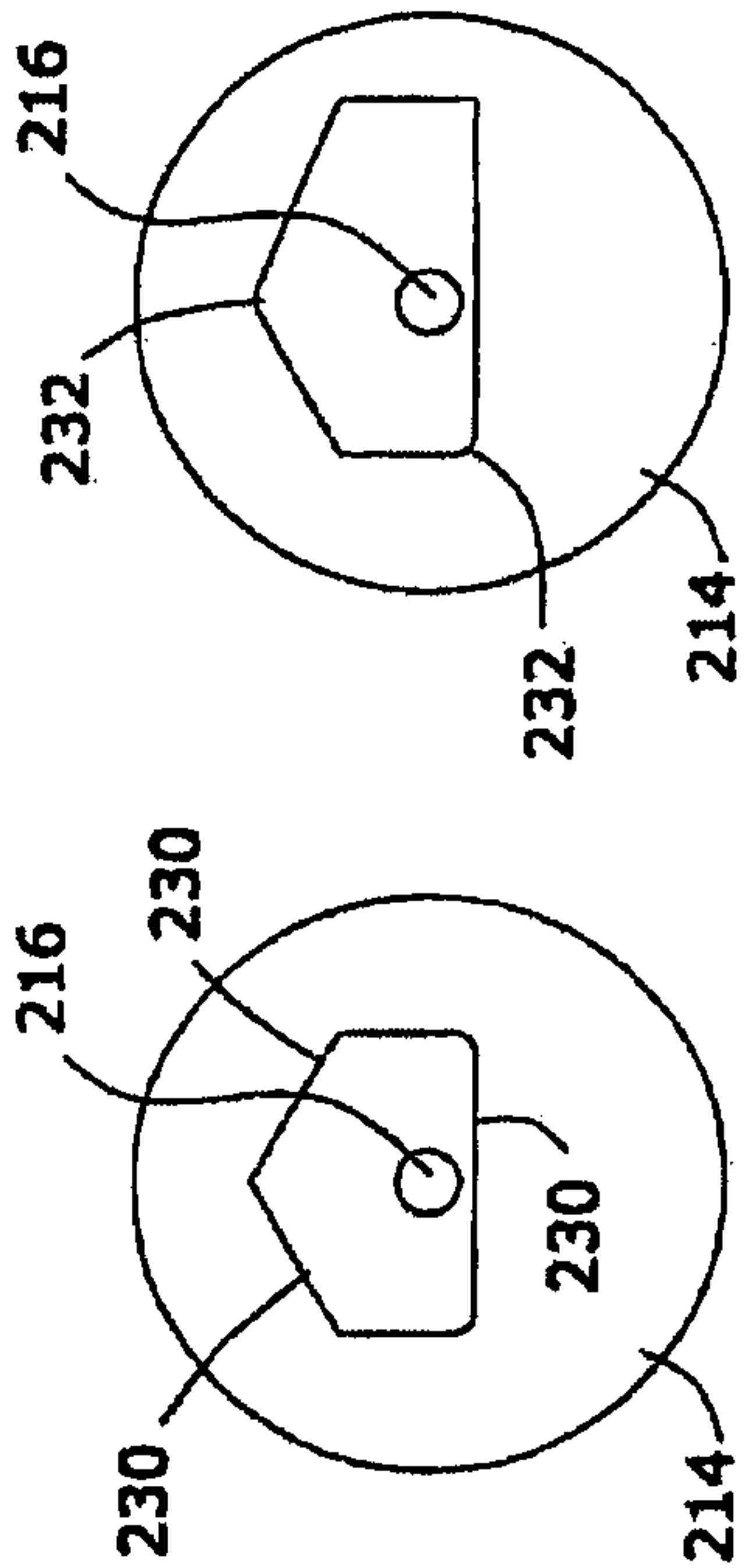


FIG. 30D

FIG. 30E

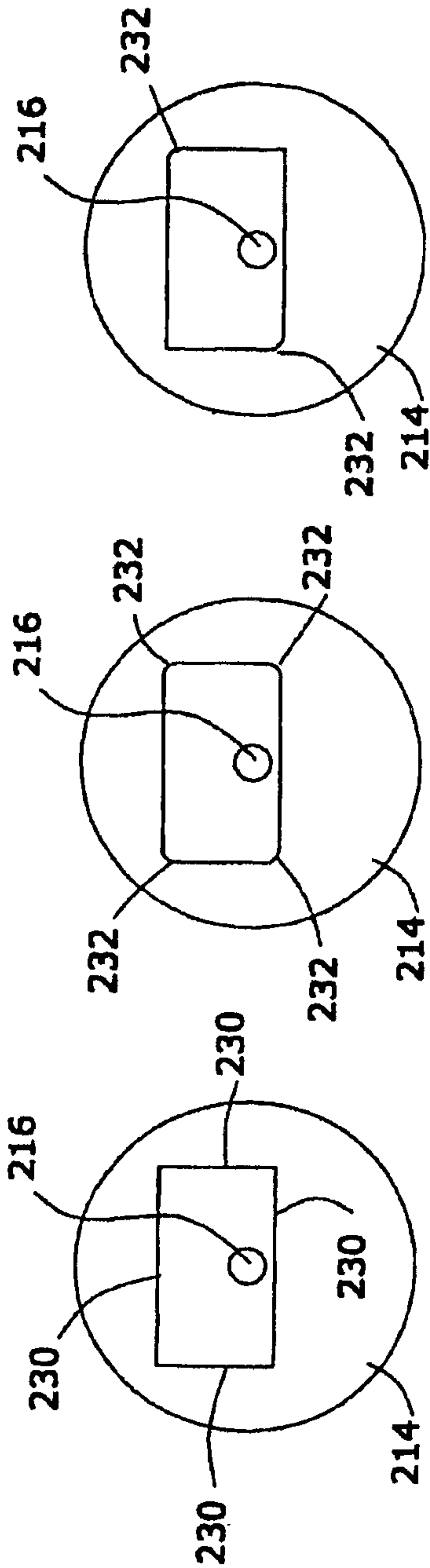


FIG. 30F

FIG. 30G

FIG. 30H

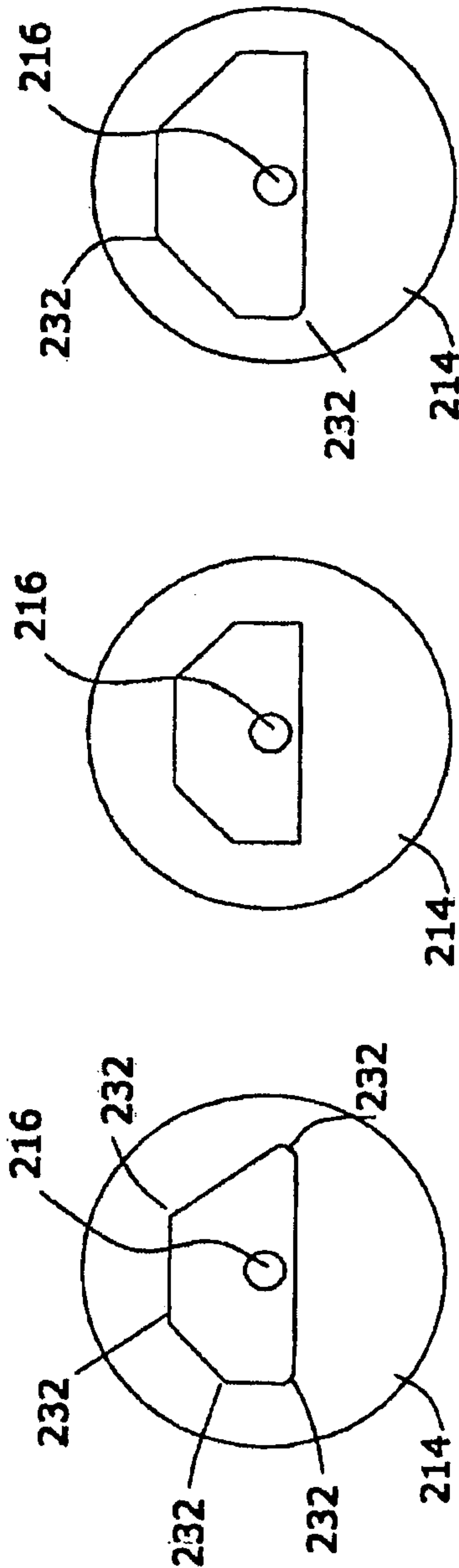


FIG. 30I

FIG. 30J

FIG. 30K

FIG.31A

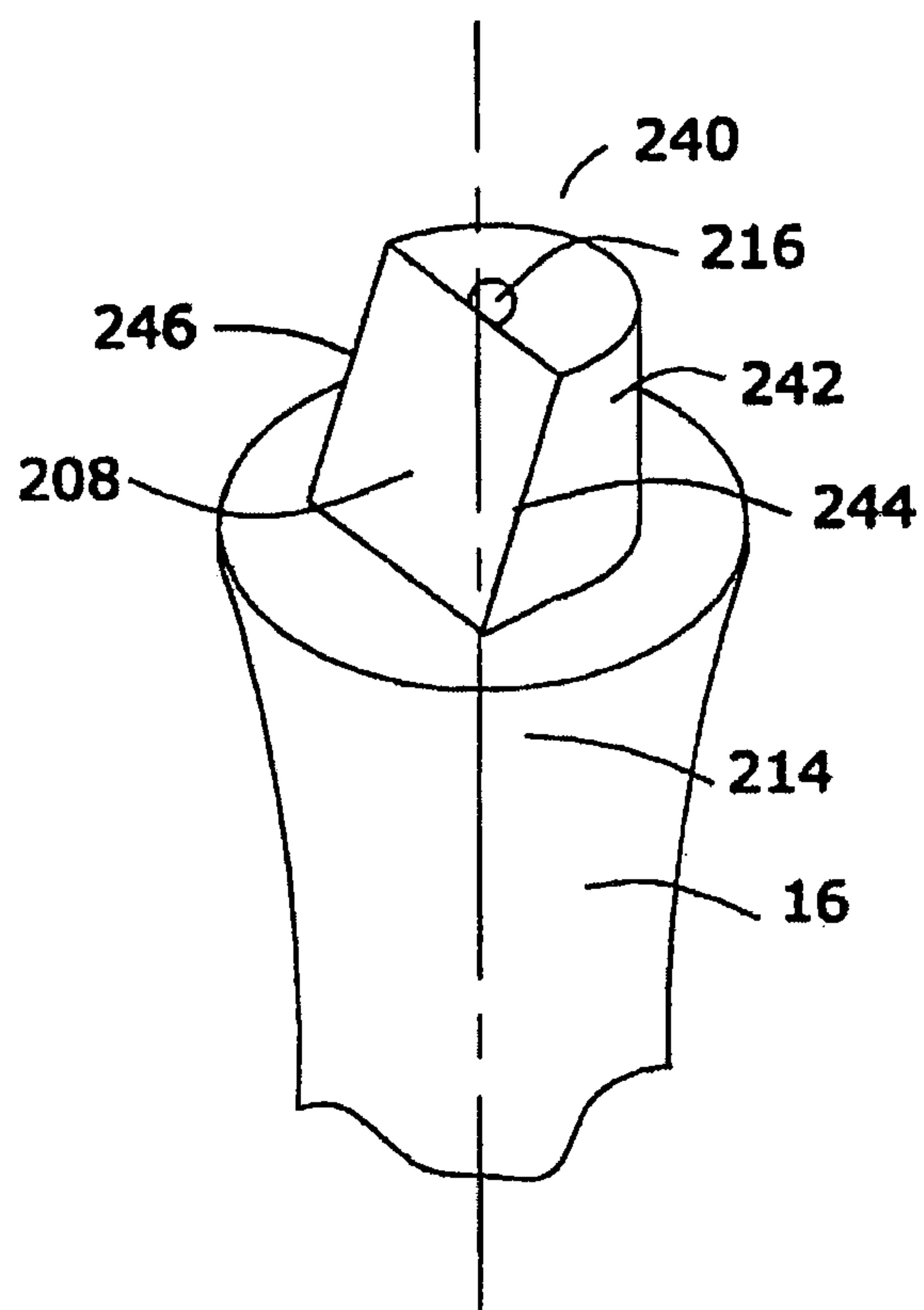
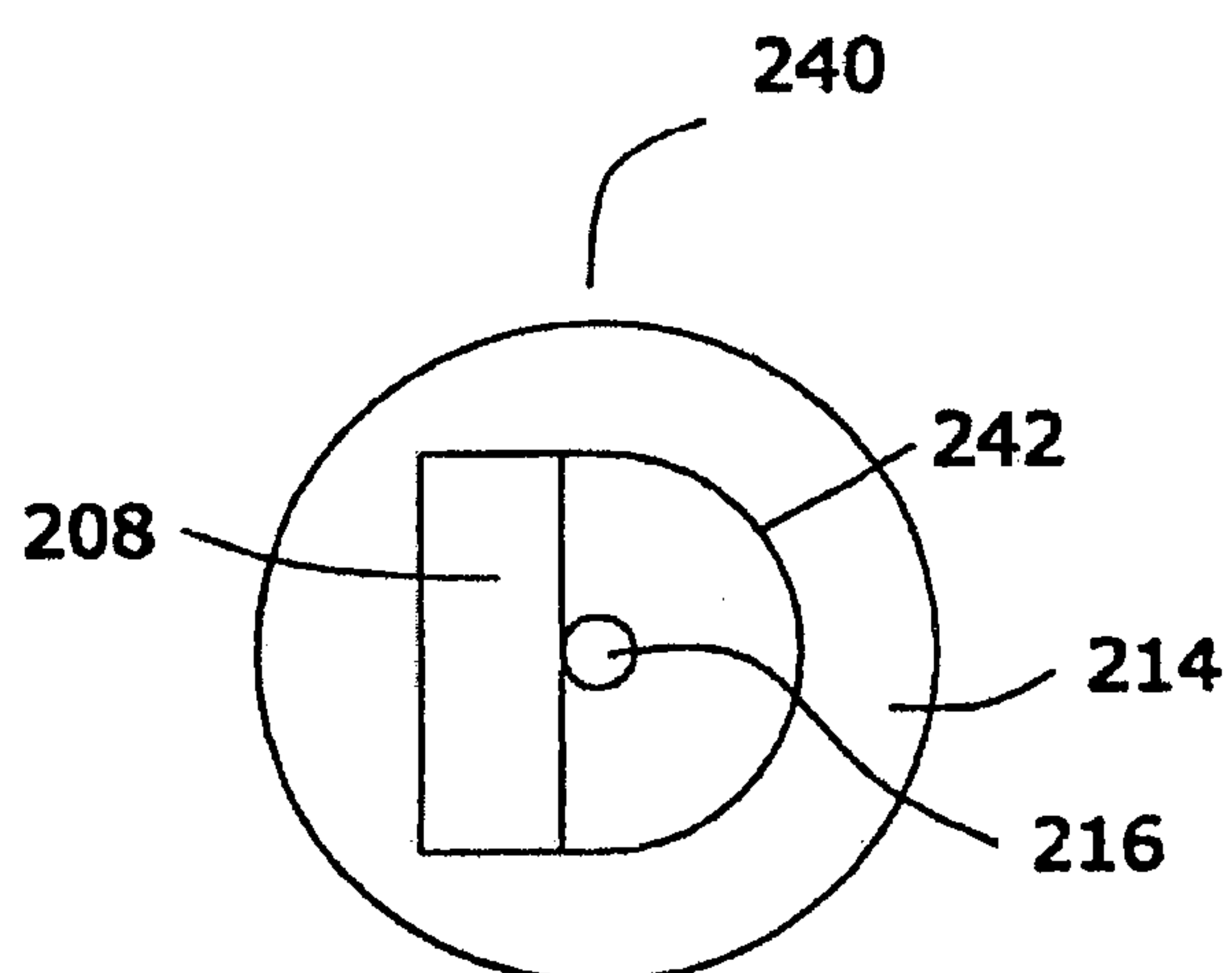
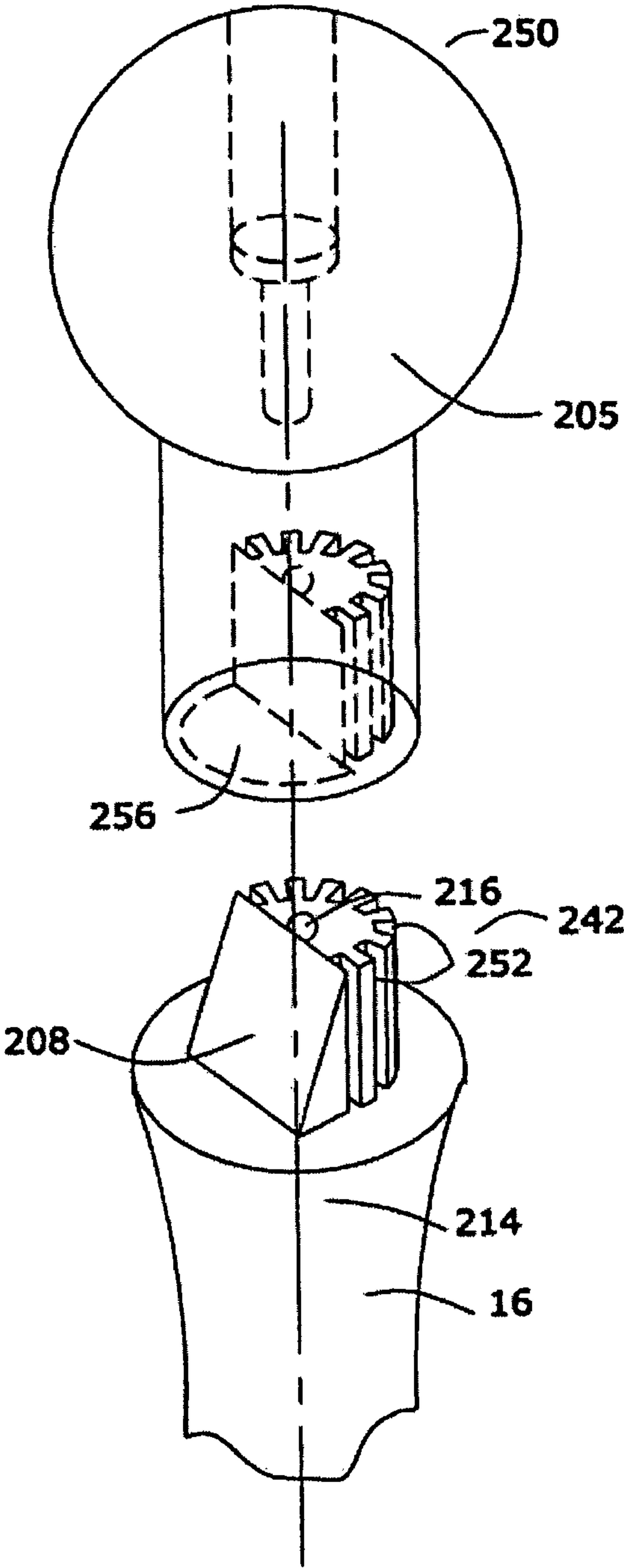


FIG.31B





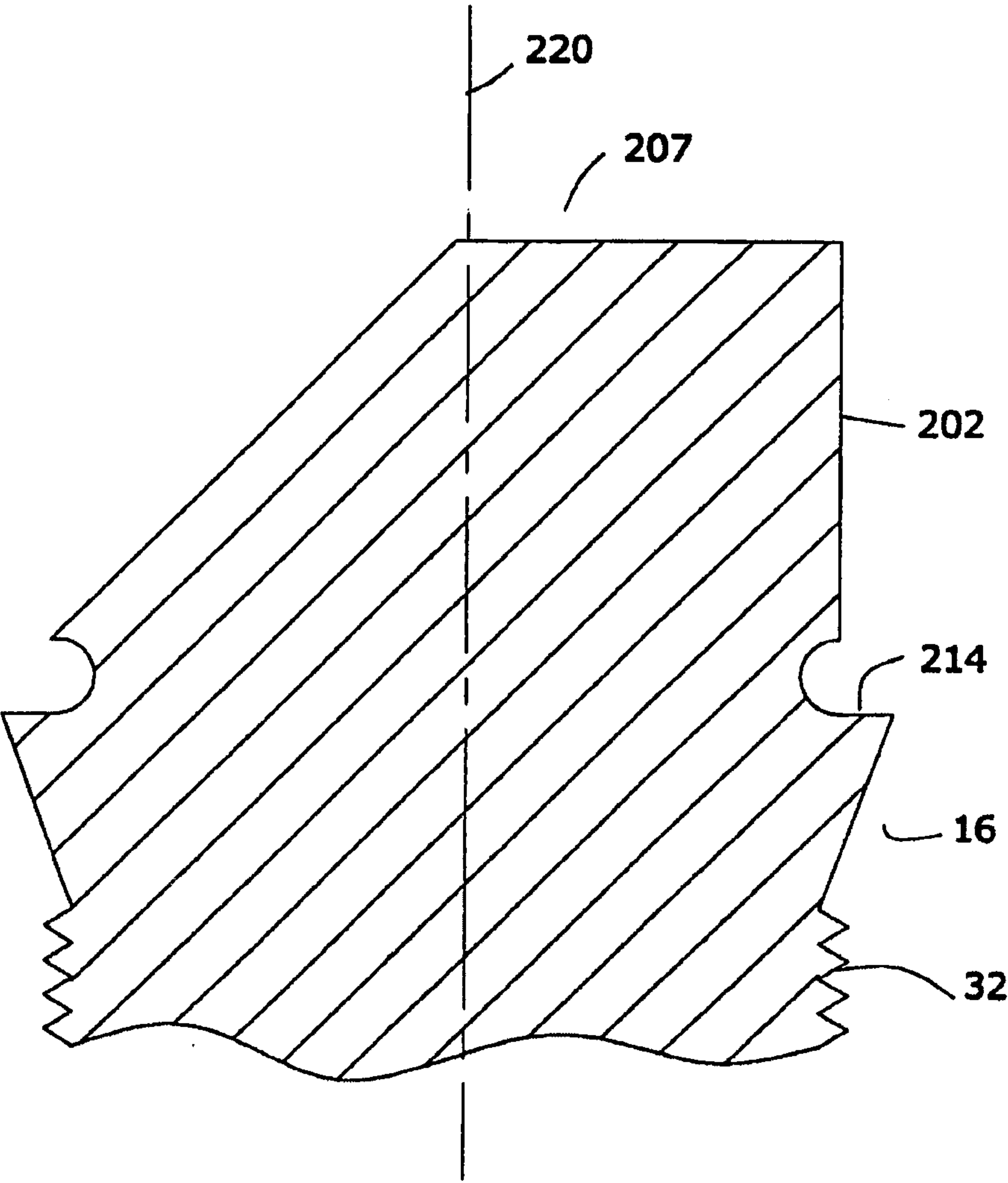


FIG. 32A



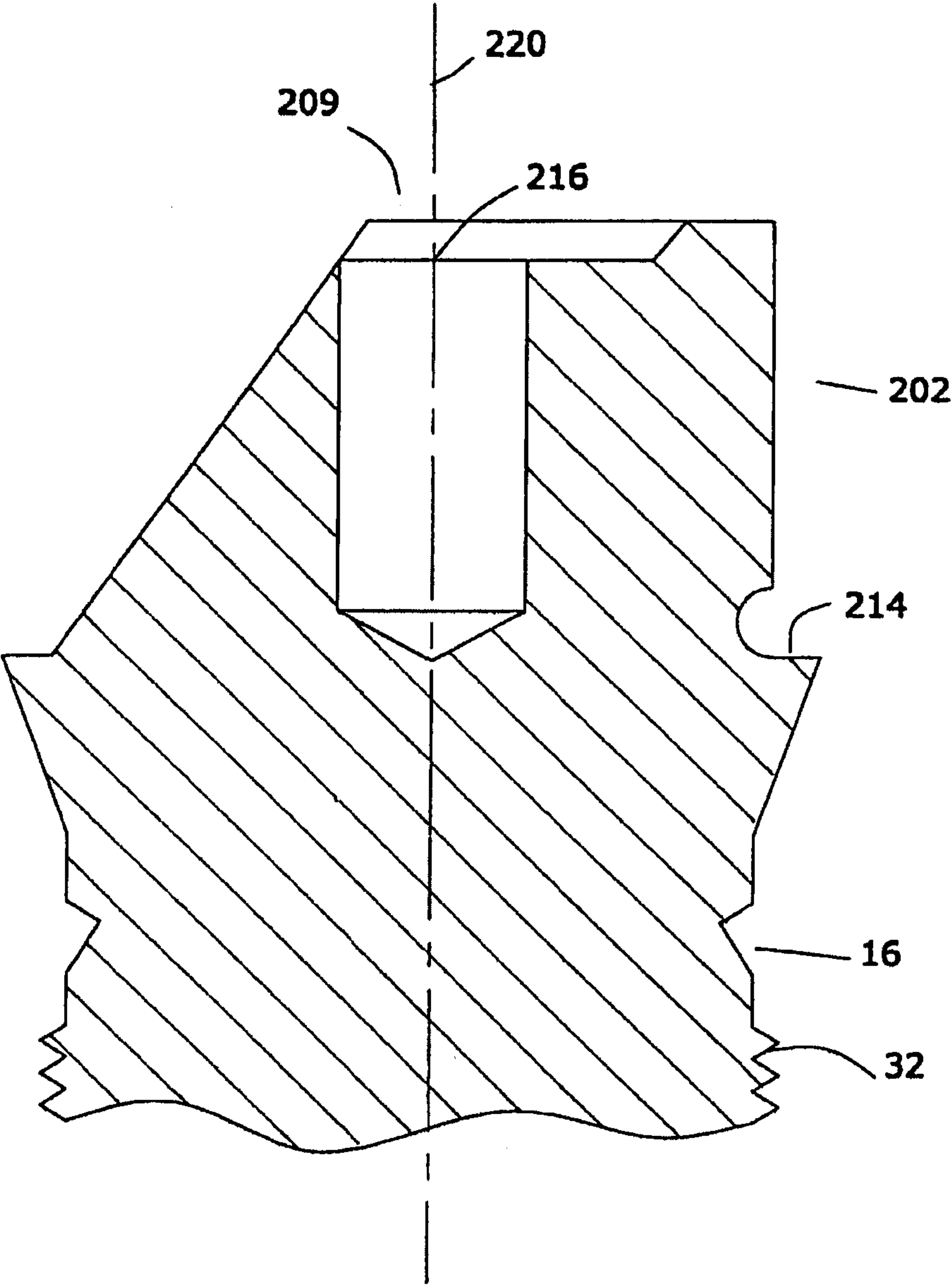


FIG. 32B

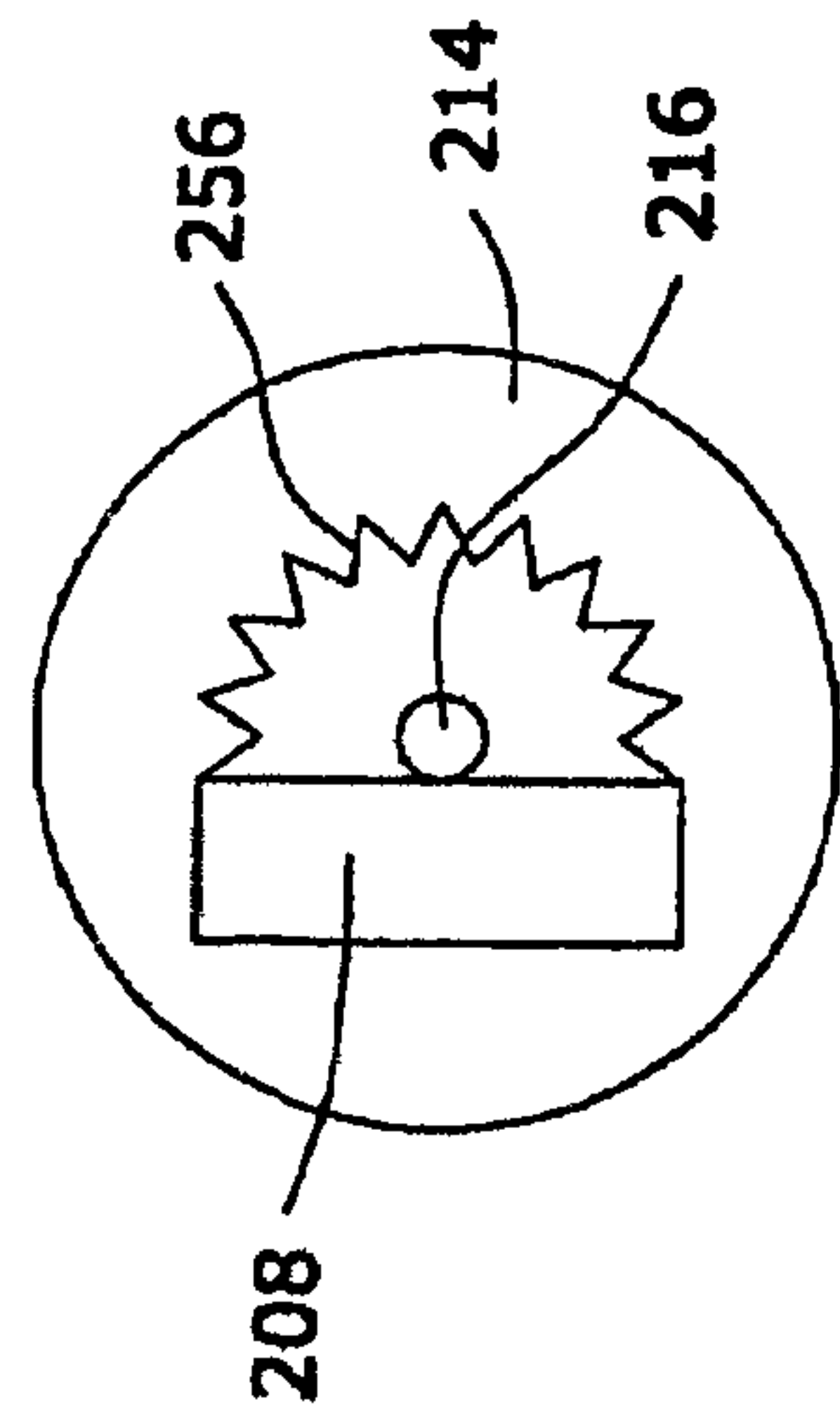


FIG. 33A

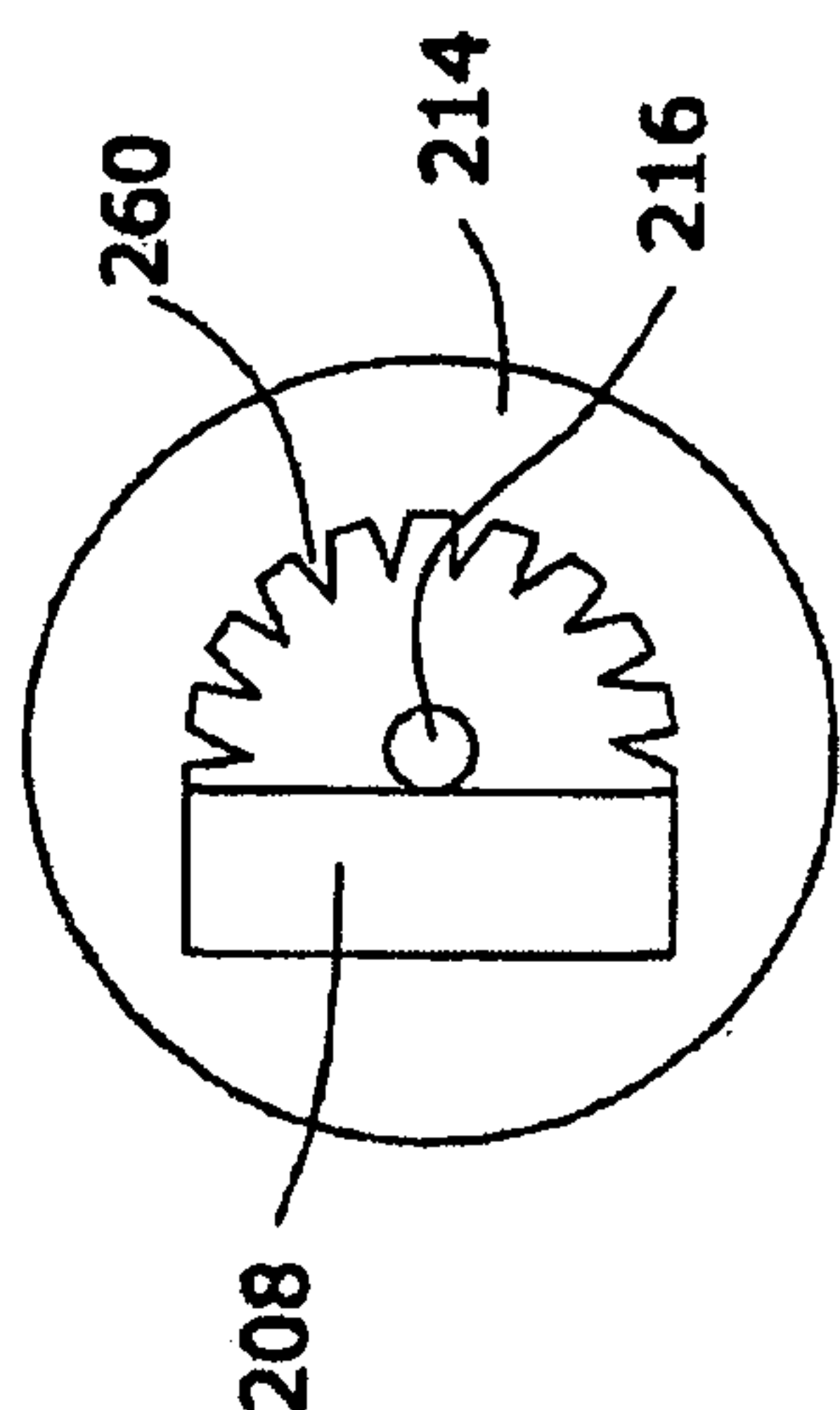


FIG. 33B

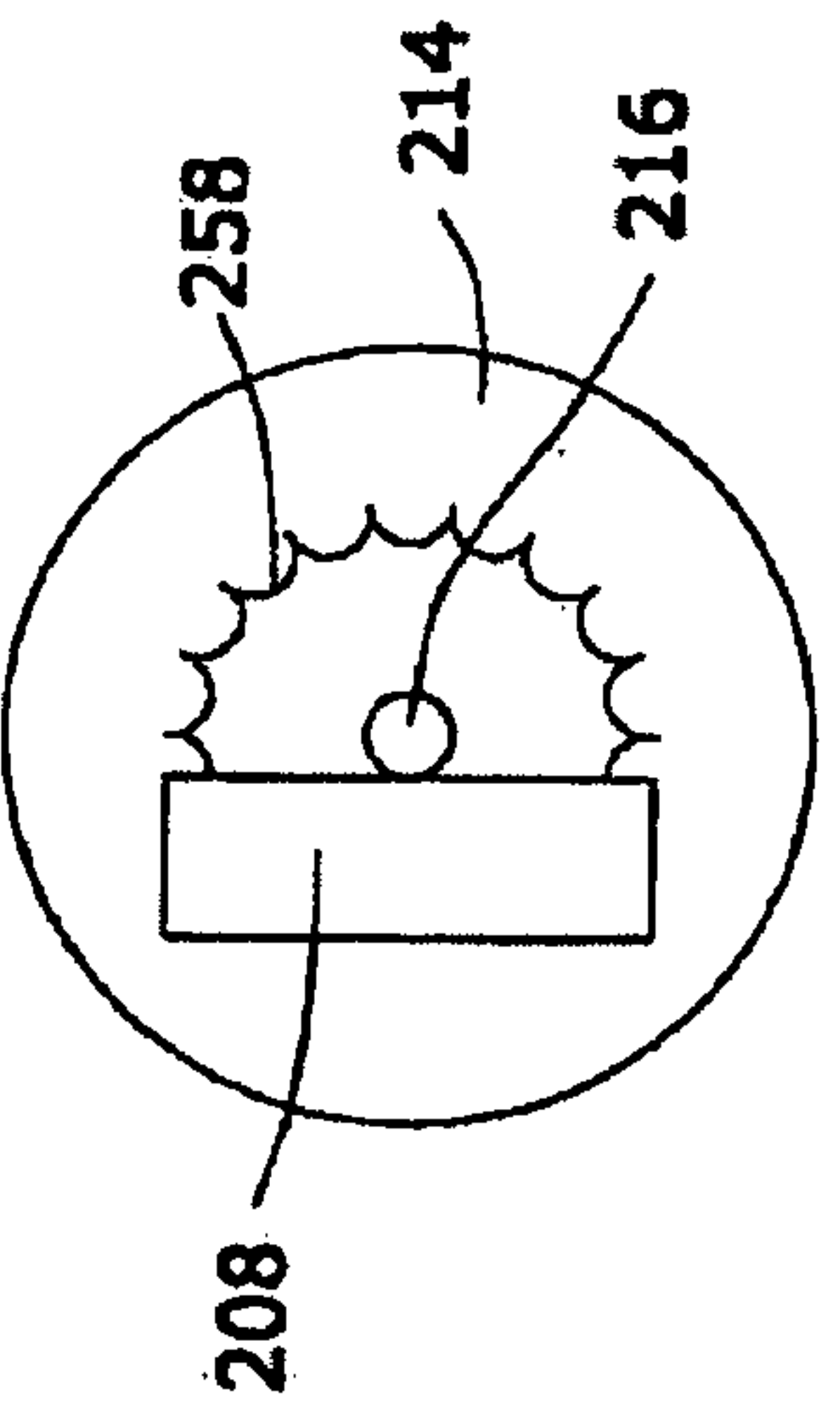


FIG. 33C

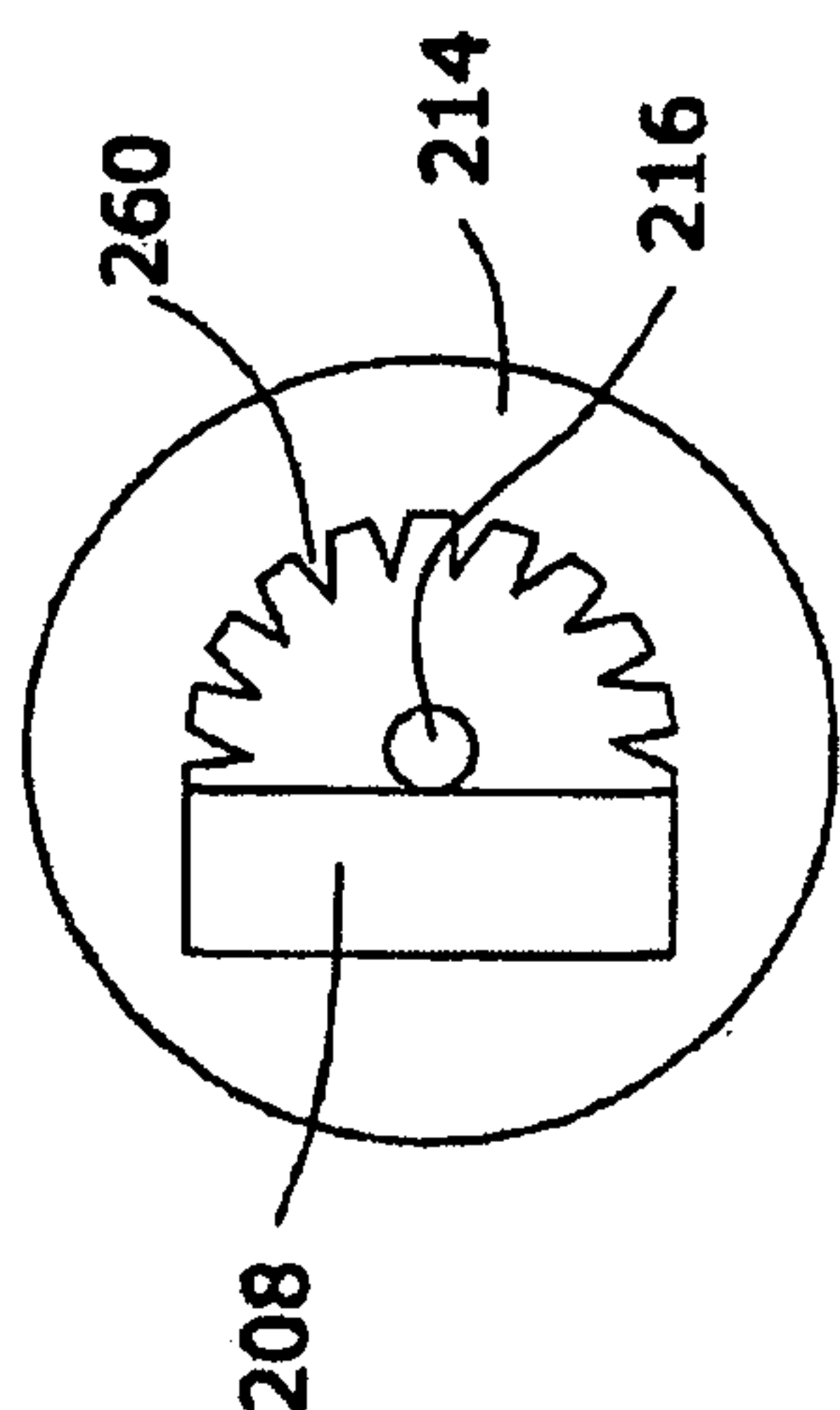


FIG. 33D

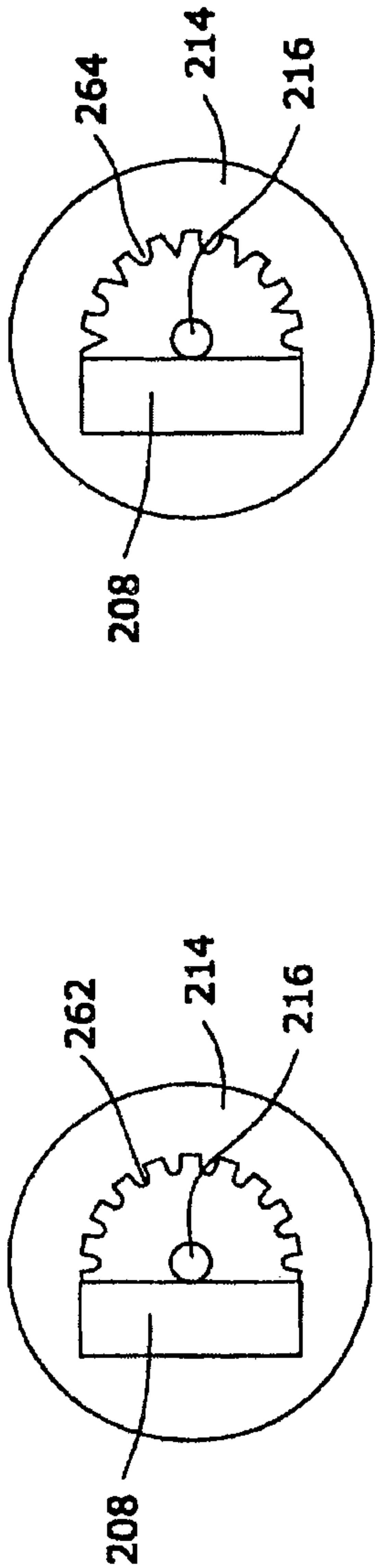


FIG. 33E

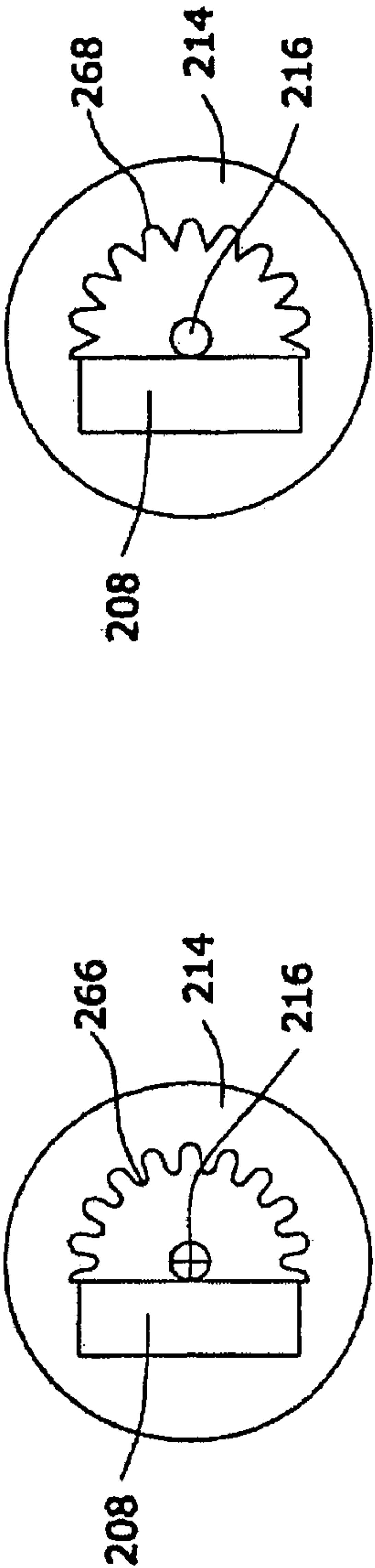


FIG. 33G

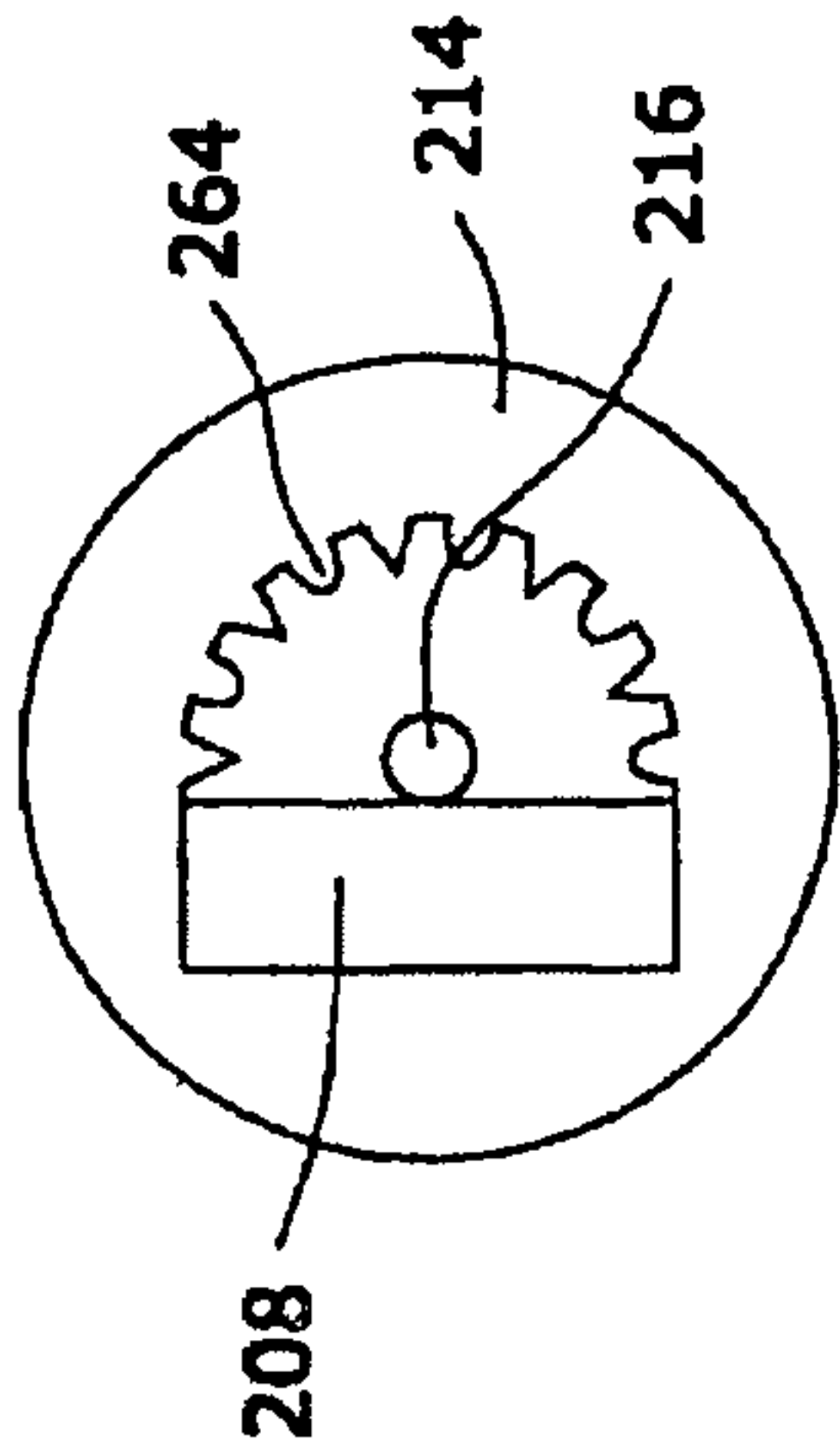


FIG. 33F

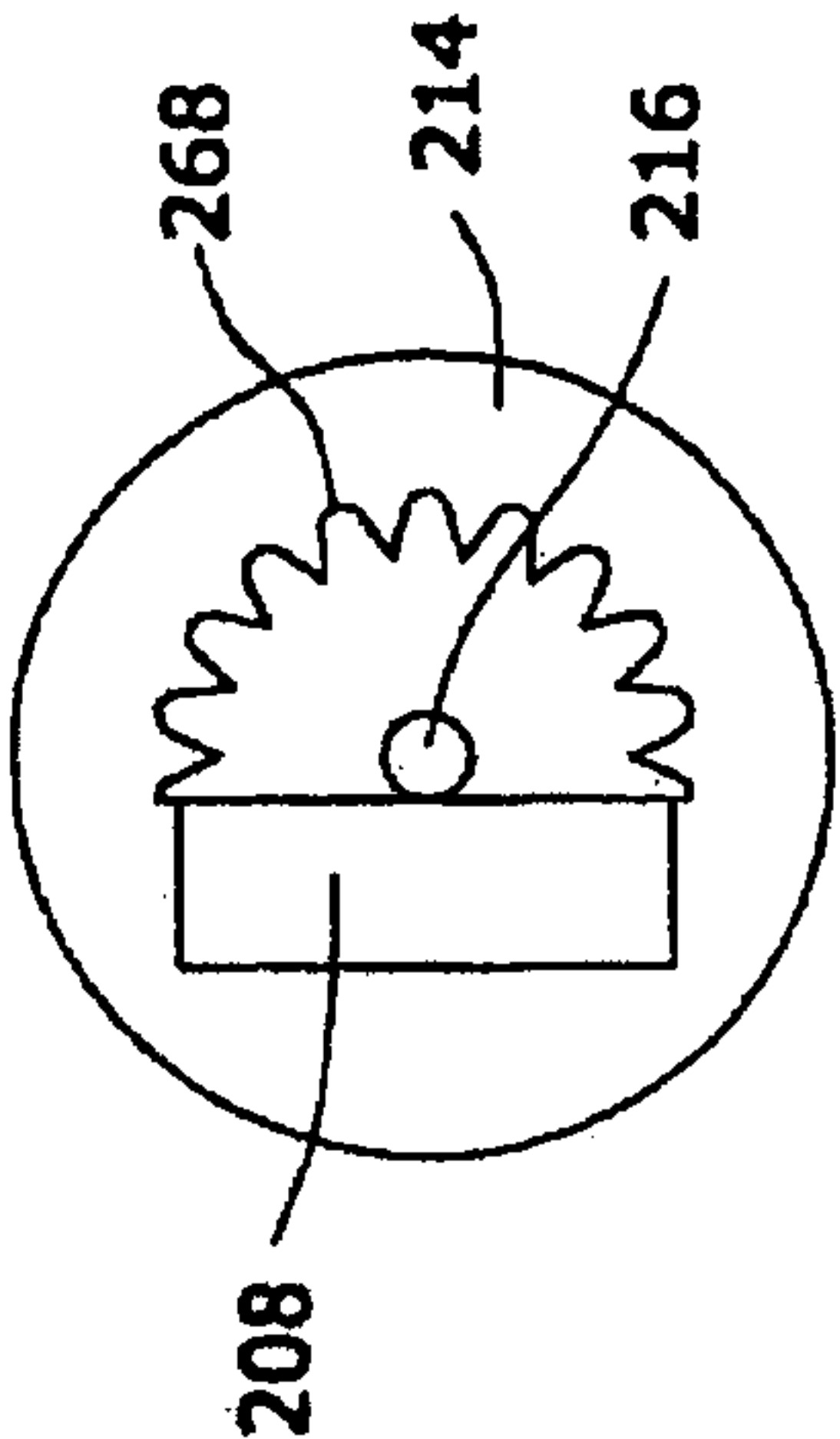
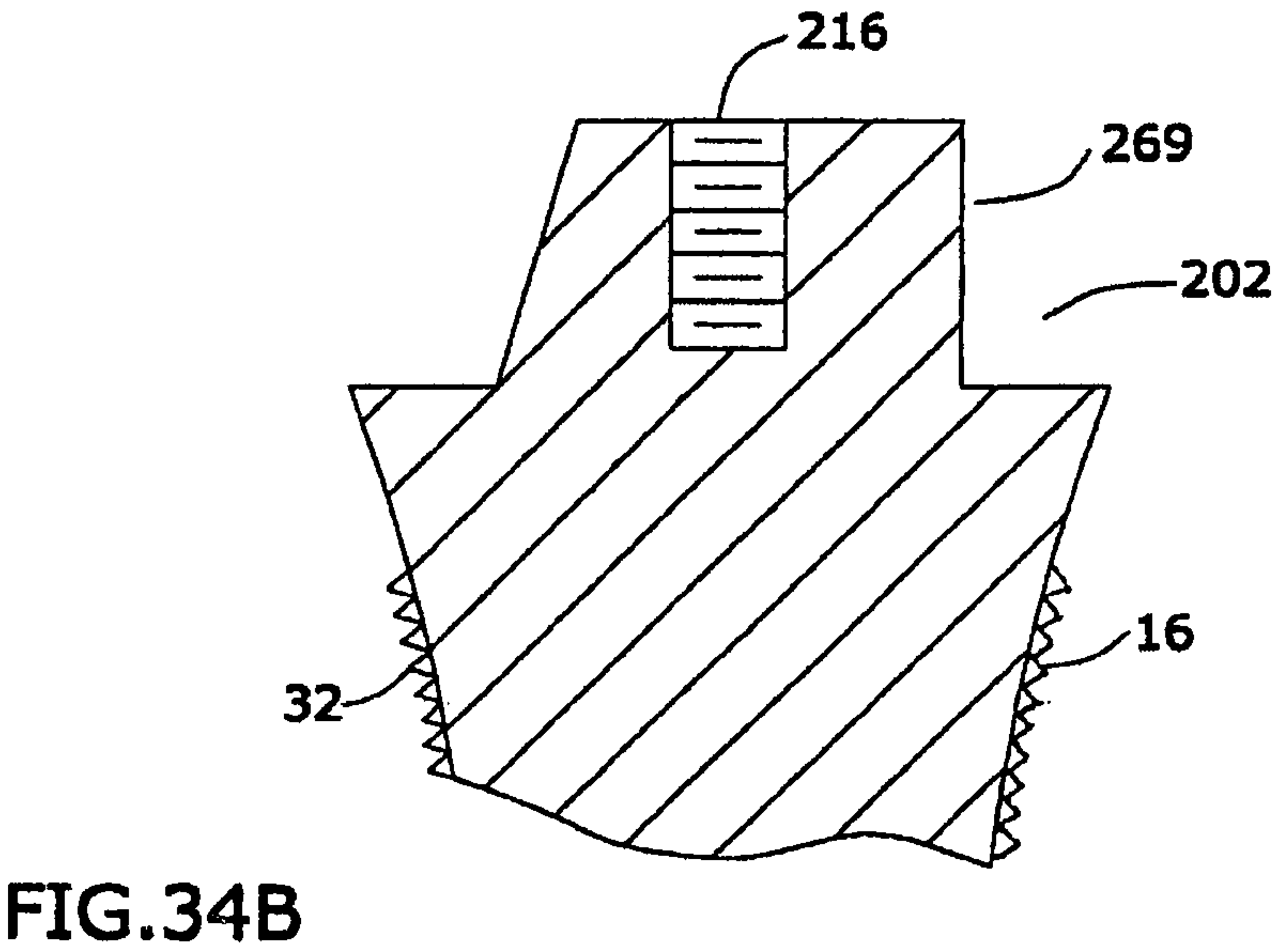
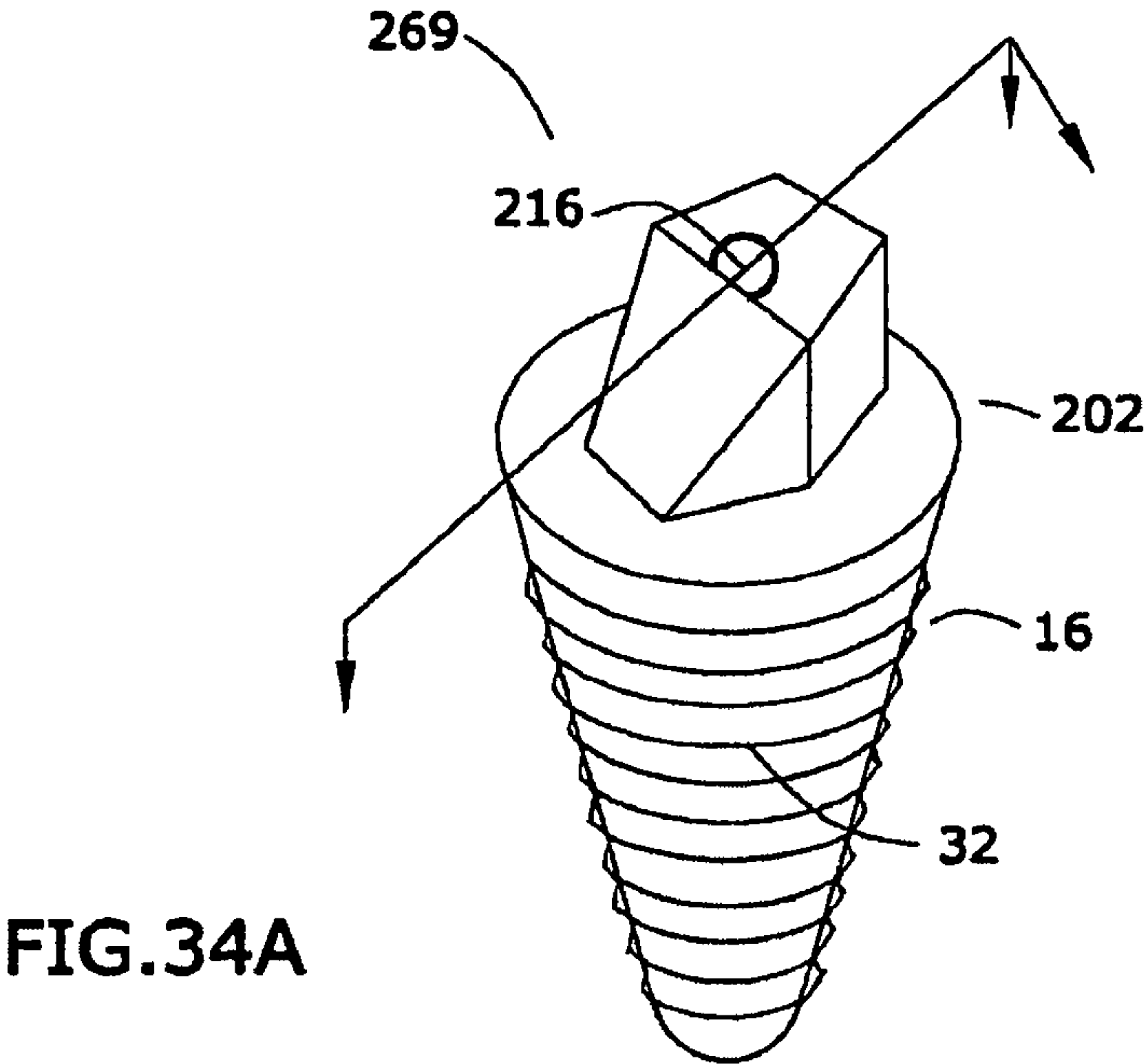
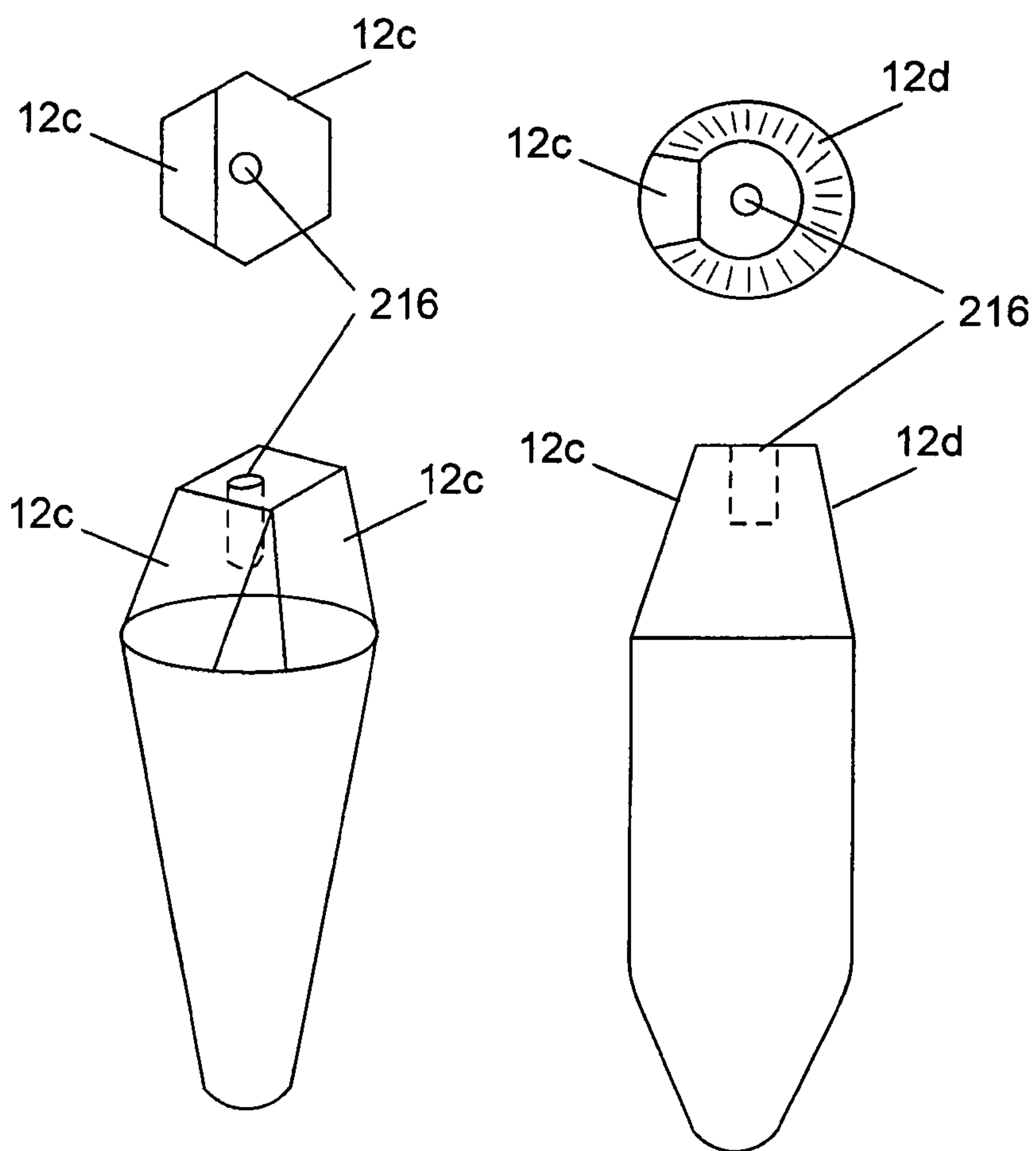


FIG. 33H





**FIG. 34C**

**FIG. 34D**

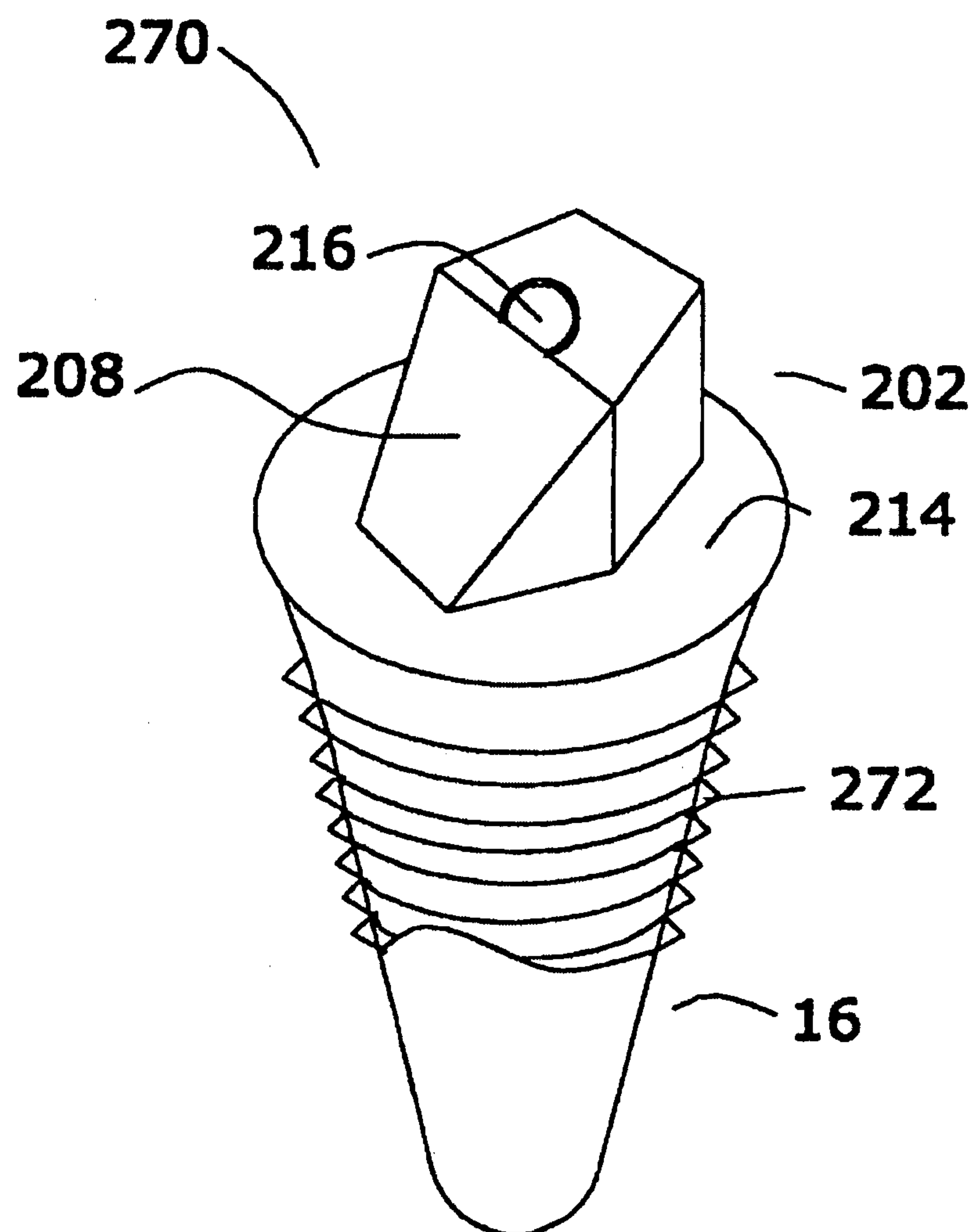


FIG.35

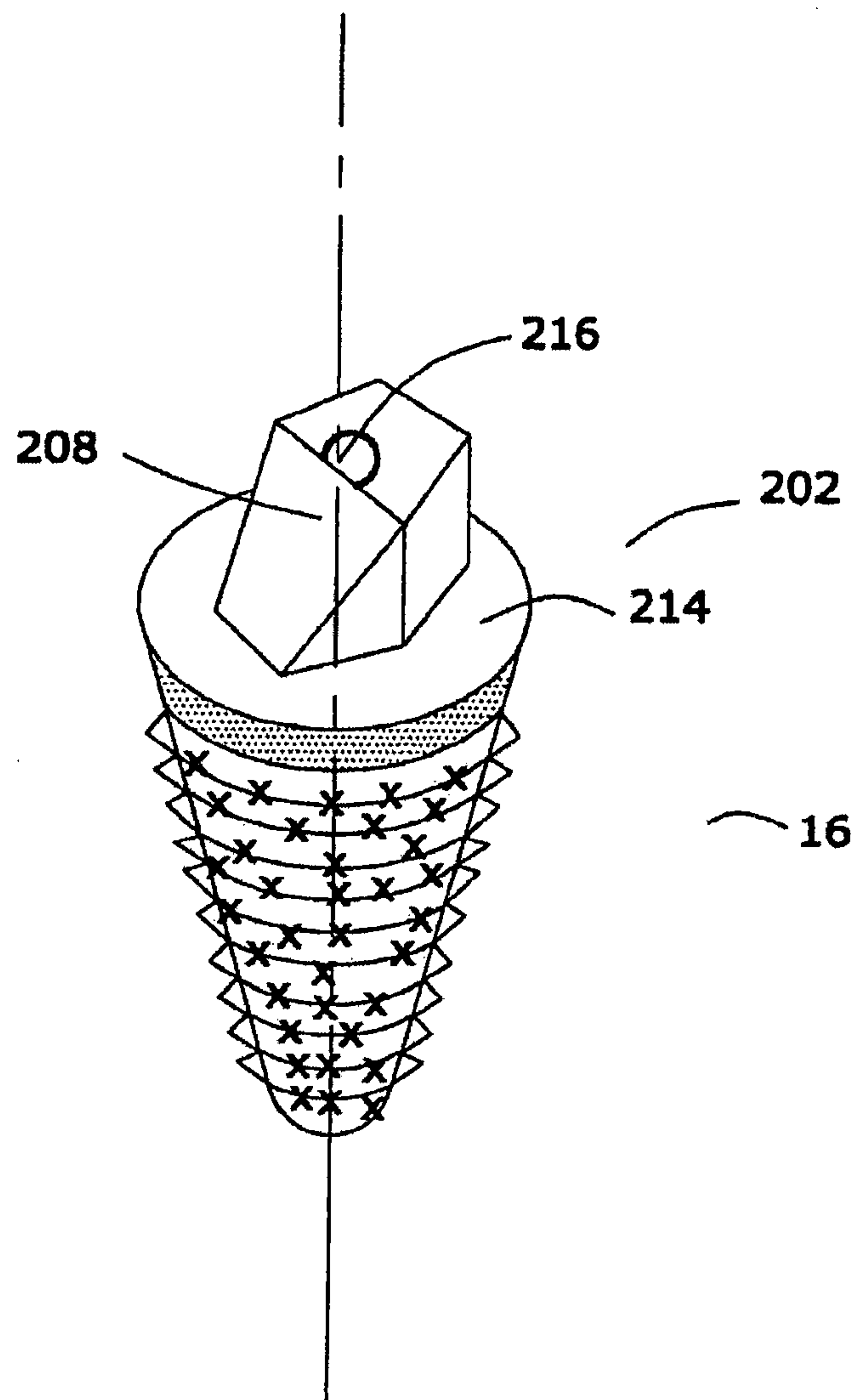


FIG.36



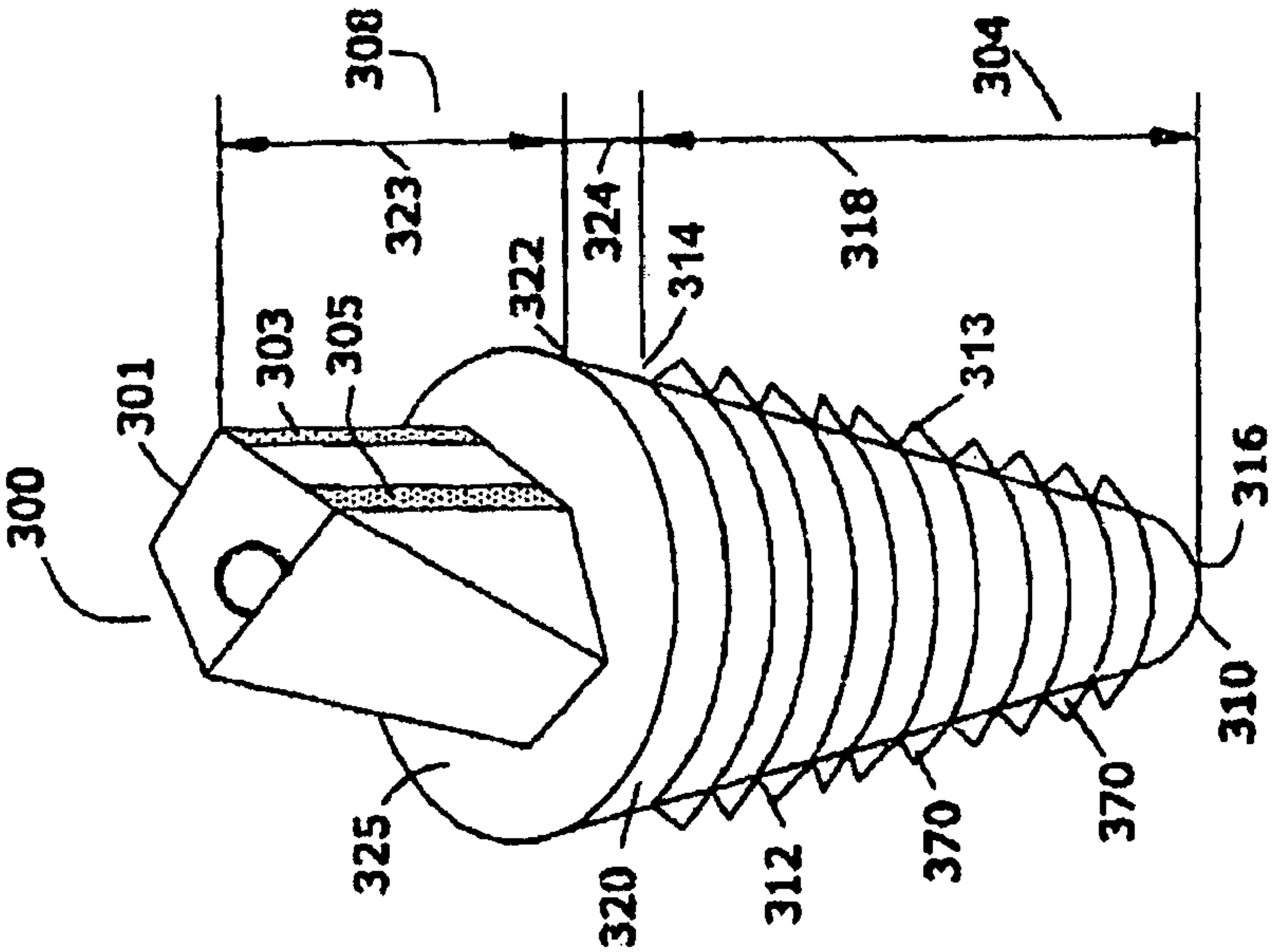


FIG. 37A

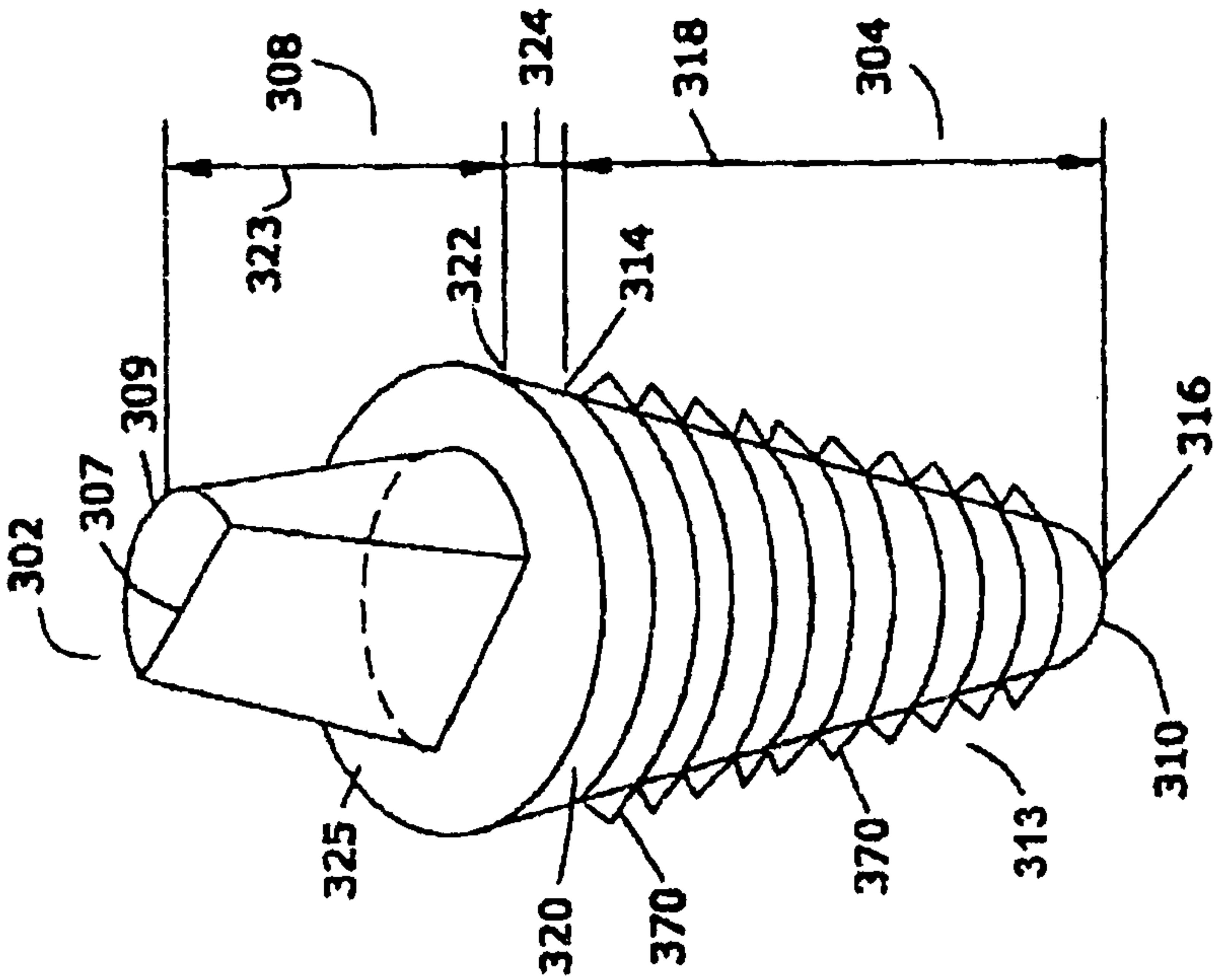


FIG. 37B

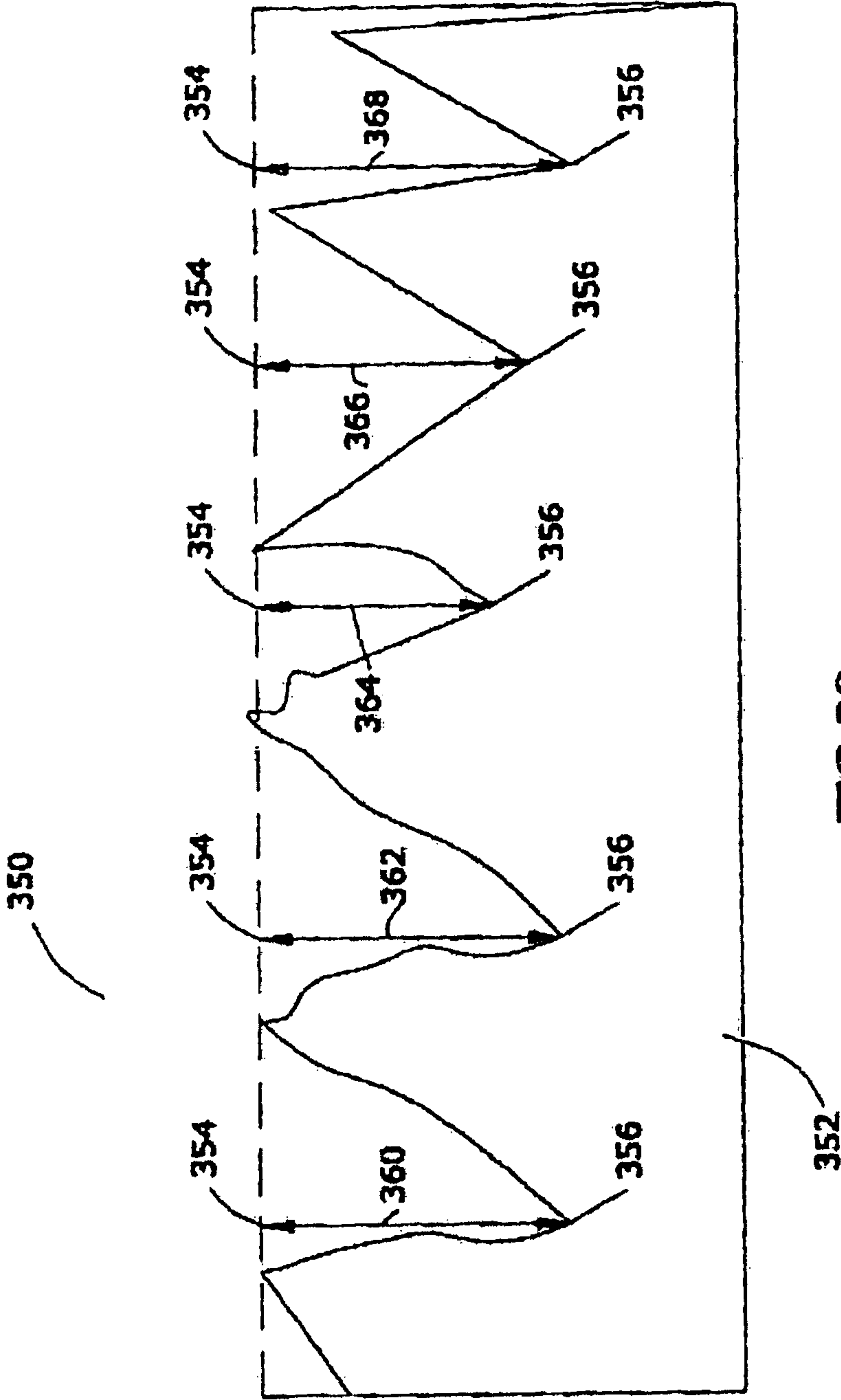


FIG. 38

## 1

**DENTAL IMPLANT SYSTEM AND  
ADDITIONAL METHODS OF ATTACHMENT****CROSS-REFERENCE TO RELATED  
APPLICATIONS**

This application is a continuation of applicant's patent application U.S. Ser. No. 11/288,465, filed Nov. 29, 2005 now abandoned, which is a continuation-in-part of U.S. Ser. No. 10/195,007, filed on Jul. 12, 2002 now U.S. Pat. No. 7,207,800, which is a continuation-in-part of U.S. Ser. No. 09/967,556, filed on Sep. 28, 2001 now abandoned, which claimed priority from U.S. Ser. No. 60/237,222, filed on Oct. 2, 2000 and from U.S. Ser. No. 60/236,518, filed on Sep. 29, 2000. The content of each of the aforementioned patent applications is hereby incorporated by reference into this specification.

**FIELD OF THE INVENTION**

A dental implant device comprised of an irregularly-shaped abutment.

**BACKGROUND**

Dental implants have been known and used since at least the 1930's; see, e.g., U.S. Pat. No. 5,312,254 of Joel L. Rosenlicht. See also U.S. Pat. No. 5,145,371 of Lars Jorneus which discusses the osseointegration method of integrating a dental implant into a patient's jaw. The disclosure of each of these patents is hereby incorporated by reference into this specification.

A wide variety of dental implant styles and systems are currently available. For example, dental implants having cutting means are also known in the art, as disclosed in U.S. Pat. No. 5,338,197, the disclosure of which is hereby incorporated by reference into this specification. Another type of dental implant assembly is one that uses a hexagonal abutment implant system. This assembly is disclosed in U.S. Pat. No. 5,564,924, of which the disclosure is also herein incorporated by reference.

Applicant has described several dental implant devices in U.S. Pat. Nos. 5,338,197; 5,564,924; 5,733,124; and 6,068,479; the entire disclosure of each of these United States patents is hereby incorporated by reference into this specification. Furthermore, reference also may be had to applicant's International Patent Numbers WO0226157A1 and WO9625895A1, the entire disclosure of each of these applications is also hereby incorporated by reference into this specification.

It is an object of this invention to provide an improved dental implant device.

**SUMMARY OF THE INVENTION**

In accordance with this invention, there is provided a universal dental implant system containing a head portion and a base portion. The base portion includes fastening elements to secure the implant within a jawbone of a patient. The head portion is comprised of a multiplicity of linear walls, at least one of which is disposed angularly in a manner different than the other such walls. The head portion is to receive and support false teeth.

**BRIEF DESCRIPTION OF THE DRAWINGS**

The invention will be described by reference to the following drawings, in which like numerals refer to like elements, and in which:

## 2

FIG. 1A is a schematic view of one apparatus of the invention;

FIG. 1B is a top view of the apparatus of FIG. 1A;

FIG. 1C, FIG. 1D, FIG. 1E, FIG. 1F, and FIG. 1G are side views of another embodiment of the present invention;

FIG. 1H is a bottom view of another embodiment of the present invention;

FIGS. 1I to 1N are illustrations of hole configurations for use with the apparatus depicted in FIG. 1H;

FIGS. 1O and 1P are side views of one embodiment of the invention that utilizes holes disposed within longitudinal channels;

FIG. 1Q is a depiction of various ledge configurations;

FIG. 1R is a profile view of one device of the present invention;

FIG. 2 is a partial side view of one one-piece universal implant abutment device;

FIG. 3 is a sectional view of the device of FIG. 1A;

FIG. 4 is a schematic view of a healing ball of a dental implant system;

FIG. 5 is a schematic of another embodiment of a healing ball of the dental implant system;

FIG. 6A is a perspective view of one embodiment of a dental implant system of the present invention as inserted within the jawbone of a patient;

FIG. 6B is a perspective view of another embodiment of a dental implant system of the present invention as inserted within the jawbone of a patient;

FIG. 7 is a schematic view of an analog-abutment of a dental implant system;

FIG. 8 is a perspective view of a retaining screw of a dental implant system;

FIG. 9 is a perspective view of a guide pin of a dental implant system;

FIG. 10 is a schematic view of an incision formed as part of a process of attachment of the dental implant system in accordance with the present invention;

FIG. 11 is a schematic illustration of a tissue flap formed as part of the methods of attachment of a dental implant system;

FIG. 12 is a schematic illustration of a hole formed as part of the methods of attachment of the dental implant system in accordance with the present invention;

FIG. 13 is a schematic illustration of an implant abutment device inserted within the hole of FIG. 12;

FIG. 14 is a schematic illustration of a healing ball seated on the device of FIG. 13;

FIG. 15 is a schematic illustration of an impression tray;

FIG. 16 is a schematic illustration of an impression formed as part of the process of attachment of a dental implant system;

FIG. 17 is a schematic illustration of an analog-abutment inserted within the impression of FIG. 16;

FIG. 18 is a schematic illustration of a model formed as part of the process of attachment of the dental implant system;

FIG. 19 is a schematic illustration of one embodiment of a prosthesis formed as part of the process of attachment of the dental implant system;

FIG. 20 is a schematic illustration of multiple implant abutment devices inserted within the jawbone of a patient;

FIG. 21 is a schematic illustration of another embodiment of an impression tray;

FIG. 22 is a schematic illustration of one embodiment of an alignment of multiple implant abutment devices of a dental implant system;

FIG. 23 is a schematic illustration of another embodiment of multiple implant abutment devices modified as part of the methods of attachment of the dental implant system;



3

FIG. 24 is a schematic illustration of yet another embodiment of multiple implant abutment devices modified as part of the methods of attachment of the dental implant system;

FIG. 25 is a schematic illustration of another embodiment of a modified implant abutment device;

FIG. 26 is a schematic illustration of a section of a template of the dental implant system;

FIG. 27 is a schematic illustration of one embodiment of a section of a template positioned on an implant abutment device;

FIG. 28 is an exploded view of an embodiment of an abutment used in the device of this invention;

FIGS. 28A and 28B are perspective views of other abutment assemblies;

FIG. 28C is a side exploded view of another embodiment of the present invention;

FIG. 29 is top view of the abutment of FIG. 28;

FIGS. 29A and 29B are top views of other abutment assemblies;

FIGS. 30A, 30B, 30C, 30D, 30E, 30F, 30G, 30H, 30I, 30J, and 30K are top views of other abutment assemblies;

FIGS. 31A and 31B are perspective and top views, respectively, of another implant assembly of the invention;

FIG. 32 is an exploded schematic view of an implant assembly of the invention;

FIGS. 32A and 32B are sectional views of abutment assemblies of the invention;

FIGS. 33A, 33B, 33C, 33D, 33E, 33F, 33G, and 33H are top views of other abutment assemblies of the invention;

FIG. 34A is a perspective view of another implant assembly of the invention;

FIG. 34B is a sectional view of another implant assembly of the invention;

FIG. 34C and FIG. 34D are side views of two additional embodiments of the present invention;

FIGS. 35, 36, 37A and 37B are perspective views of other implant assemblies of the invention; and

FIG. 38 is a sectional view of a roughened surface.

#### DETAILED DESCRIPTION OF A PREFERRED EMBODIMENT

In general, dental implants are moderately expensive, ranging in cost from approximately two to four hundred dollars (excluding laboratory costs). However, the labor associated with the implant procedure often costs eight to twenty times the amount of the implant itself, ranging from about three to four thousand dollars per tooth. One of the reasons for this substantial cost is the multiplicity of steps required by the implant procedure. An example of these prior art steps will be described below with reference to Nobelpharma catalog PRI 385 94, 2nd edition (published by the Nobelpharma AB, Box 5190, S-402 26 Goteborg, Sweden).

In the first step of the prior art procedure, an implant or "fixture" is purchased; see, e.g., page 7 of the Nobelpharma catalog and the reference to the 3.75 millimeter and 4.0 millimeter titanium fixtures illustrated on such page. The fixture so purchased must then be placed into an "instrument set for fixture placement," which is shown on page 22 of the Nobelpharma catalog.

Once the fixture is disposed in the "instrument set . . . 2," a "fixture mount" is then attached to the fixture by means of a wrench and a screwdriver. The "fixture mount" devices are shown on page 22 of the Nobelpharma catalog. The instruments for fixture placement of the fixture are also shown on page 22 of the Nobelpharma catalog (see wrench part 17 and screwdriver part 19).

4

Next, a "connection to contra-angle handpiece" (see part 11 on page 22 of the Nobelpharma catalog) is attached to a handpiece (see page 31 of the Nobelpharma catalog) and the implant assembly is then driven into the jawbone of a patient.

Thereafter, the fixture mount is removed from the fixture and a cover screw 10 (see page 9 of the Nobelpharma catalog) is inserted into the fixture. Next, the surgical site is allowed to heal for about three to about six months. See, e.g., Branemark/Albrektsson: "Tissue Integrated Prostheses" (Quintessence Books, 1985).

After the healing period, the implant is exposed by surgical procedures and the cover screw is removed. A healing abutment (see page 39 of the Nobelpharma catalog) is then attached to the fixture. In general, the healing abutment is left in place for approximately two to three weeks, depending upon how the patient's tissue has healed.

Thereafter, the healing abutment is removed and an implant abutment is attached to the fixture. The type of implant abutment used will depend on the requirements of the patient. Thus, for example, referring to pages 38 and 39 of the Nobelpharma catalog, one may use a standard abutment, an "EsthetiConee" abutment, a "CeraOneo" abutment, a "Ball Attachment," an Angulated Abutment," and other standard and/or proprietary abutments.

Next, the desired prosthesis is formulated by conventional means and adjusted to fit within the patient's mouth. For a single-tooth prosthesis, generally one to two impressions are made to capture the size and shape of the abutment to the tooth.

Multiple mock-ups and adjustments are often made before the final prosthesis is finally secured to the implant.

For a multiple-tooth prosthesis, the course of treatment is not always predictable; multiple impressions and frameworks need to be created involving multiple appointments. Typically, the entire treatment, including initial implant placement and second stage surgery, would span a period of time ranging from two to approximately nine to eighteen months, or longer, before the final prosthesis is secured within the patient's mouth.

In addition to the increased time, labor and costs, various theoretical and practical implications need to be considered for multiple tooth or full-mouth reconstruction. In multiple restorations, "draw," "common path of insertion," "parallel," "passivity" and "stability" are terms that describe the most critical objectives of such a procedure.

Draw is perhaps best described as the effects of friction, but not binding.

Multiple implants and their abutments are rarely, if ever, perfectly aligned within the patient's mouth. Traditional methods of multiple tooth restoration require the heads/abutments and prostheses to be modified or made parallel until a common path of insertion is achieved and until the prosthesis is passive with respect to all of the abutments and soft tissue. In other words, it must be possible to place the prosthesis in position by moving the structure onto the abutments in a straight line (i.e., the common path of insertion), with sufficient friction or draw to ensure a firm fit. Once in place, the prosthesis must be passive, which means it must fit the abutments and the soft tissue profile such that there is no undue tension and no motion can take place.

These prior art procedures require a myriad number of instruments and parts, typically two surgical procedures, many trips by the patient to the dentist, increased treatment times and prolonged healing periods resulting in an overall reduced quality of life for the patient. Further, an expensive, time consuming and labor intensive "trial and error" system is crucial to such procedures because each prosthesis is custom



## 5

made to the particular shape, design, location and quantity of abutments for each patient. Therefore, not only are the processes tedious and expensive, but, also, each surgical procedure introduces a certain element of risk, pain, and suffering.

In view of the above, there is a need for a dental implant system and associated process of attachment that are simple, predictable and effective. In particular, it is desirable that the dental implant system and attachment process include universal, interchangeable components, reduce post-operative infection, improve device/prosthesis strength and prolong its stability, and reduce the overall time for reconstruction procedures. It is also desirable that the dental implant system and associated process enable a practitioner to form a final prosthesis, including an infinite number of facsimiles of said final prosthesis, based on a single impression.

One embodiment of the present invention contemplates a method of dental reconstruction comprising inserting one or more devices into an edentulous space within a patient's mouth, wherein each of the devices includes a head portion. The method further includes placing a healing ball on each of the heads of the devices and forming a dental impression with impression material, wherein the healing balls transfer with the impression material upon removal from a patient's mouth. In addition, the method includes mounting an analog-abutment within each of the healing balls of the impression, forming a final model of the dental impression including the analog abutments, wherein the final model replicates the patient's edentulous space and creating a final prosthesis using the final model. Lastly, the method includes installing the final prosthesis within the edentulous space of the patient. The present invention also contemplates a universal dental implant system comprising a head portion and a base portion, wherein the base portion includes fastening elements to secure the implant within a jawbone of a patient. The system further includes a healing ball, wherein the healing ball mounts onto the head portion.

In addition, the system further includes a retaining screw or guide pin that secures the healing ball onto the head portion.

In addition, one embodiment of the present invention also contemplates a method of forming a dental prosthetic comprising fixing a stud element in a predetermined site, placing a removable protective element on the stud element and forming a first impression over the protective element at the predetermined site. The method also includes removing the protective element from the stud element with the first impression, mounting an abutment in the protective element contained in the first impression, forming a second impression over the abutment such that the second impression substantially replicates the predetermined site, and creating a prosthesis by relying on information provided by the second impression.

Another embodiment of the present invention contemplates a method of forming a dental prosthetic comprising providing a first impression which replicates a dental site, inserting a fixation element into the first impression, providing a second impression which replicates the dental site and retains the fixation element and modifying the fixation element on the second impression as needed so as to provide sufficient information to create the prosthetic.

Yet another embodiment of the present invention contemplates a model for creating a dental prosthetic comprising a form replicating the region of an edentulous space within a patient's mouth, the form having an analog abutment protruding from the region, and the analog abutment having a modification created to ensure insertability and removability of a prosthetic within a patient's mouth.

## 6

FIG. 1A is a schematic illustration of one implant system. Referring to FIG. 1A, an embodiment of a dental implant system in accordance with the present invention includes a one-piece universal implant abutment device **10**. In general, the universal implant abutment device **10** is a single-piece device **10** including head **12**, neck **14** and base **16** sections. It should be noted that this device **10** is a single-piece component.

However, it is to be understood that the disclosure of the present invention may also apply to devices including one or more elements. Further, the universal implant system of the present invention may be used to treat both humans and animals alike.

The implant abutment device **10** shown in FIG. 1A is preferably made of titanium or titanium alloy. Alternatively, the device **10** may be made of one or more other materials including, but not limited to, metals and/or metal alloys, such as gold, silver, palladium, vanadium, cobalt alloy, stainless steel and the like, plastics, ceramics. Thus, by way of further illustration, one may use one or more of the materials disclosed in U.S. Pat. No. 5,373,621; U.S. Pat. No. 5,372,660; U.S. Pat. No. 5,358,529; U.S. Pat. No. 5,354,390; U.S. Pat. No. 5,334,264; U.S. Pat. No. 5,326,362; U.S. Pat. No. 5,205,921; and U.S. Pat. No. 5,191,323; the disclosures of which are hereby incorporated by reference into this specification.

The device material should be biocompatible, nontoxic (e.g., medical grade) and provide sufficient strength and structural integrity when implanted within the jawbone of a patient.

Referring again to FIG. 1A, the height HY and diameter HX of the head **12** of the implant abutment device are approximately within the range of 1.0 millimeter to about 10.0 millimeter, and 1.0 millimeter to 12.0 millimeters, respectively. In one embodiment of the invention, the height HY and diameter HX of the head are approximately 3.0 mm and 3.8 mm, respectively. The associated height NY and diameter NX of the neck **14** of the implant abutment device **10** are approximately within the range of 0 millimeters to 8.0 millimeters and 1.0 millimeter to 12.0 millimeters, respectively.

In another embodiment, the walls of the head are extending downwardly and outwardly to intersect with the base. Reference may be had to FIG. 1C and FIG. 1D. In the embodiments depicted, base section **16** is comprised of threads (not shown). In the embodiments depicted, head **12** is comprised of a top head section **12a** and a bottom head section **12b**. The walls of head **12** extend downwardly and outwardly from top head section **12a** to bottom head section **12b**. In the embodiment depicted, the diameter of bottom head section **12b** is the same as the diameter of the upper base section of base **16**. In the embodiment depicted in FIG. 1C, the abutment head **12** is formed by a linear wall **12c** and arcuate wall **12d**. In the embodiment depicted in FIG. 1C, the head **12** is formed by two linear walls, **12c**, that are opposite one another, and two arcuate walls **12d**, that are also opposite one another. In other embodiments, not shown, head **12** is comprised of more than four walls wherein there is a pattern of alternating linear and arcuate walls. In the embodiments depicted in FIG. 1C and FIG. 1D, the neck section (see neck section **12** of FIG. 1A) is absent. In another embodiment, such a neck section is present.

Referring now to FIG. 1E, and to the embodiment depicted therein, device **10** depicted therein is comprised of head section **12**, neck section **14** and base section **16**. The embodiment depicted in FIG. 1E is similar to the embodiment depicted in FIG. 1C except in that the device illustrated in FIG. 1E includes neck section **16**. As shown in FIG. 1E, neck section



16 is comprised of vertical walls 16a and 16b. In another embodiment (not shown), the walls 16a and 16b can be converging or diverging to intersect with the bottom of the head 12. In the embodiment depicted, vertical walls 16a and 16b are substantially parallel. FIG. 1E also differs from FIG. 1C in that FIG. 1E illustrates axial hole 17.

In the embodiment depicted in FIG. 1E, axial hole 17 has a depth 17b and a width 16c. Axial hole 17 is orientated such that its depth 17b is substantially parallel to axis 220. Axial hole thus makes the base partially hollow. In one embodiment, a biologically active agent can be embedded in a carrier substance such as collagen sponge, strip, wick and the like; and is disposed within axial hole 17. Such an agent may be delivered to the surrounding tissue through holes 17a. In the embodiment depicted, holes 17a connect axial hole 17 to the external environment and permit the transmission of the aforementioned biologically active agent. In the embodiment depicted, the holes are perpendicular to axis 220. In another embodiment, not shown, the holes are at a non-perpendicular angle relative to axis 220.

In addition, the height BY and diameter BX of the base 16 of the device 10 are within the range of approximately 6.0 millimeters to 30.0 millimeters and 1.0 millimeter to 12.0 millimeters, respectively.

Alternative heights and diameters can also be used provided that the overall device dimensions permit proper implantation and functioning of the device 10.

As shown in FIGS. 1A and 1B, and in the embodiment depicted therein, the perimeter of the head 12 is substantially in the shape of a hexagon and includes six, planar, external main-walls 18. In one embodiment, the six, planar main-walls 18 are interconnected by six, substantially planar, external side-walls 20. In general, the width MW of each main-wall 18 is approximately within the range of 1.0 millimeter to 12.0 millimeters and the width SW of each sidewall 20 is approximately within the range of 0 millimeters to 12.0 millimeters. In another embodiment of the invention, the head configuration includes substantially planar main-walls 18 and non-planar (e.g., arcuate) side-walls 20, thereby producing improved comfort and reduced irritation within the patient's mouth.

Alternatively, the main-walls 18 may be substantially non-planar and the side walls 20 planar, or both the main-walls 18 and side-walls may be substantially non-planar.

In an alternate embodiment, shown in FIG. 2, the main-walls 18 and side-walls 20 of the head 12 are tapered. The main-walls 18, side-walls 20, or portions thereof, may taper in either radially inward or outward direction. Other configurations of the head 12 including, but not limited to, cylindrical, triangular, square, and octagonal-shaped are also included within the scope of the claimed invention. Additional shapes, such as those disclosed in U.S. Pat. No. 6,068,479, of which the entire disclosure is incorporated by reference, are also contemplated for use with the present invention. For example, the configuration of the base 16 and threads 32 includes, but is not limited to, those configurations as disclosed in U.S. Pat. No. 5,338,197; U.S. Pat. No. 5,435,723; U.S. Pat. No. 5,564,924; U.S. Pat. No. 5,571,017; U.S. Pat. No. 5,601,429; U.S. Pat. No. 5,967,783; and U.S. Pat. No. 6,068,479; the disclosure of each of these patents is hereby incorporated by reference into this specification. The threads 32 serve to securely attach the base 16 of the implant abutment device 10 within the patient's jaw. Other fastening elements including, but not limited to, barbs, retractable barbs, one-way barbs and other textured surfaces may also be used with the present invention.

The cylindrical base 16 of the device 10 may be solid or partially hollow. The hollow spaces (i.e. axial hole) can accommodate foreign objects. For example, in one embodiment, the foreign body is an absorbent material (like sponges, collagen tapes, resorbable collagen) impregnated with biologically active agents that are released or come in contact with the surrounding tissue after implantation. Non-integral dental implants that have such axial holes are disclosed in U.S. Pat. No. 6,918,766 to Hall (Method, arrangement and use of an implant for ensuring delivery of bioactive substances to the bone and/or tissue surrounding the implant), the content of which is hereby incorporated by reference into this specification. Such axial holes are contemplated for use with the present invention.

As shown in FIG. 1F and FIG. 1G, the device 10 is comprised of a generally cylindrical, titanium body 19 comprises of a head 12, neck 14 and base 16, wherein the head 12 is comprised of smooth walls 208 and 242 extending downwardly and outwardly. The cross section of the head 12 is a substantially flat wall 208 joined to an arcuate wall 242. The neck 14 has the same diameter as the head 12 at the intersection, where the surface 14a of the neck 14 is etched such that the surface has an irregular roughness of from about 0.001 micron to about 1000 microns. In another embodiment, the irregular roughness of neck 14 is from about 0.01 to about 20 microns. In yet another embodiment, the irregular roughness of neck 14 is from about 3 to about 20 microns. In one embodiment (not shown), such an etching is accomplished by means of parallel grooves created by laser etching one such groove or channel is of 8 microns in size located in the neck section and another groove or channel of different size for example 12 microns located on the base section 16.

Means for obtaining such etching are known in the art. For example, reference may be had to U.S. Pat. No. 6,861,364 to Koide (Laser etching method and apparatus therefore) the content of which are hereby incorporated by reference into this specification. The walls 14b and 14c of the neck 14 are substantially parallel until each wall intersect base 16. Base 16 extends downwardly and inwardly. In the embodiment depicted, neck 14 has a length of from about 0.1 to about 6 millimeters. Base 16 is comprised of raised threads 32 that extend downwardly and inwardly to the bottom part of the base 16. The end part of base 16 has an axial hole 17 which, in the embodiment depicted, is open at the bottom of base 16. Holes 17a are in fluid communication with axial hole 17 such that the biologically active agent disposed in axial hole 17 may diffuse through holes 17a. Holes 17a extend radially through base 16 at right angles to the axis 220 (see FIG. 1E) of the device 10.

As is indicated in FIG. 1H, a second hole can also be formed in the base section 16 such that the two holes are at right angles to each other. FIG. 1H is a cross sectional view of device 10 of FIG. 1G viewed from the bottom. Hole 17a is in fluid communication with axial hole 17 as is hole 17b. There is an angle 17c between first hole 17a and second hole 17b. In the embodiment depicted, angle 17c is about ninety degrees. In another embodiment, not shown, the angle is other than ninety degrees.

The diameter of hole 17a ranges from about 0.25 to about 0.75 times of diameter BX (see FIG. 1A). In general the diameter of axial hole 17a is between 1 to 4 millimeters and the depth of the axial hole 17 is between 0.1 millimeters to the entire length of BY (see FIG. 1A). In the embodiment depicted in FIG. 1H, the cross section of axial hole 17 is a circle. In other embodiments, the cross section another shape, such as a circle, triangle, or polygonal shaped. Reference may be had to FIG. 11 to FIG. 1N. Such cross sections allow the



frictional fitting of a biologically active agent carrier body such as sponges, collagen plugs, tapes etc. In one embodiment of the invention, an absorbent collagen sponge **17d** has been used as a carrier. Such a sponge has an elastic, porous mass and absorbs the biologically active agent. In the embodiment shown, the sponge has an uncompressed diameter of about 4 millimeters and, when compressed, has a diameter of about 3.1 millimeters. It can be easily fitted in the axial hole **17**.

In the embodiment depicted in FIG. 1E, the axial hole **17** extends partially into base **16**. In the embodiments shown in FIG. 1F and FIG. 1G, the axial hole **17** extends along the whole length of base **16**, and at intervals along such base, there are transverse holes **17a**. In one embodiment, holes **17a** have a diameter of from about 0.01 millimeters to about 4 millimeters. In one embodiment, collagen sponge **17d** also extends along the entire length of base **16**.

In another embodiment, shown in FIG. 10 and FIG. 1P, the head **12** is comprised of flat wall **208** connected with arcuate wall **242**. Neck **14** is comprised of parallel walls **14b** and **14c**. In one embodiment, the parallel walls **14b** and **14c** of neck **14** are irregularly roughened. In the embodiment depicted in FIGS. 10 and 1P, base **16** is comprised of longitudinal channel **16a**. Such longitudinal channels are known in the art. Reference may be had to U.S. Pat. No. 5,338,197 which is incorporated by reference into this specification.

Longitudinal channel **16a** fluidly connects holes **17a** such that any biologically active agent secreted through holes **17a** from axial hole **17** can diffuse vertically along the length of longitudinal channel **16a** and therefore along the entire length and surrounds the whole implant in the jaw bone.

In another embodiment FIG. 1Q, device **10** is comprised of an angled ledge formed by the union of reverse curves. In the embodiment depicted in FIG. 1Q, device **10** is comprised of head section **12** and neck section **14**. Neck section **14** is comprised of ledge **26**. Ledges such as ledge **26** may have a variety of configurations. In ledge configuration **21a**, such a ledge has an acute angle. As is known to those skilled in the art, acute angles are angles measuring between 0 and 90 degrees. Angle **23a** is such an acute angle. In ledge configuration **21b**, such a ledge has a right angle. Such a ledge is said to be a horizontally extending ledge. Angle **23b** is a right angle. In ledge configuration **21c**, such a ledge has an obtuse angle. An obtuse angle is an angle whose measurement is between 90 and 180 degrees. Angle **23c** is such an obtuse angle. Configuration **21d** shows one embodiment of the invention wherein no ledge is present. Instead, the angle **23d** between head **12** and neck **14** is 180 degrees. In another embodiment (shown in FIG. 1Q), a sloping, obtuse angle is formed where the ledge joins the bottom part of the head **12** joining the neck **14** in the form of a curvature in a downwardly and outwardly sloping configuration, then curving downwardly and inwardly to join with the top part of the base **16**. In this embodiment, the ledge formed would have no distinct angles, but maintains an overall obtuse angle.

Device **10** illustrated in FIG. 1Q has a head section **12** which is comprised of a plurality of splines (formed by alternating half circles or alternate arcuate walls of different sizes and in alternating reverse arrangements or defined by half circles joined by arcuate tops) **258** with a substantially circular cross-sectional shape. In the embodiment depicted, four such splines **258** are illustrated. In another embodiment, more than four such splines are present. See, for example, FIG. 33C. Splines **258** are configured to have a mating configuration with lower section **42** of healing ball **40**. Such a mating configuration only permits the healing ball to be attached to

device **10** in a finite number of orientations. In one embodiment, there is only one such possible orientation.

In another embodiment, illustrated in FIG. 1R, the head **12** has a mated configured adapted to receive a correspondingly shaped instrument. In the embodiment depicted, head **12** has a length of from about 1 millimeter to about 8 millimeters and consist of an arcuate wall **242** extending downward and outward. The bore **216** can be different configurations. In the embodiment depicted, bore **216** has a substantially hexagonal cross-sectional shape. Bore **216** is adapted to engage a correspondingly shaped instrument. The neck **14** is comprised of parallel **14b** and **14c** and has a length of from about 0 to about 6 millimeters. In one embodiment, the surface of neck **14** is irregularly roughened as disclosed elsewhere in this specification. Base **16** is a cylinder with walls extending downward and inward. In the embodiment depicted, base **16** is both threaded and etched to produce an irregularly roughened surface. In another embodiment, base **16** is comprised of axial hole **17** with fluidly connected holes **17a** and **17b**. Both holes **17a** and **17b** are at right angles relative to axial hole **17**. In the embodiment depicted, holes **17a** and **17b** are also at right angles relative to one another. Base **16** is also comprised of longitudinal channel which connects at least two holes **17b** on the outer surface of base **16**.

The structural design of the base **16** depends, in part, on the material or materials used to fabricate the device **10**. For example, in one embodiment, a base **16** made of a semi-rigid material may be solid, whereas a base **16** made of a substantially rigid material may be partially hollow. Alternatively, a base **16** made of a combination of rigid and semi-rigid materials may include solid and hollow portions. Alternate configurations of the base **16** not disclosed herein are also included within the scope of the claimed invention.

Referring to FIG. 3, a substantially cylindrical, hollow core **34** extends through and along the axial length, or portions thereof, of the head **12** of the device **10**. The surface of the internal walls **36** of the head **12** surrounding the core **34** may be threaded and slightly tapered. Alternative core **34** and surrounding wall/wall-surface designs and configurations including smooth, dimpled, grooved, hexagonal, polygonal, tapered, stepped, arcuate and other configurations and combinations thereof, may also be used and are also included within the scope of the claimed invention. In one embodiment, the hollow core **34** is adapted to receive and securely retain a guide pin, retaining screw and/or healing ball, as described in further detail below.

In alternate embodiments (not shown), the hollow core **34** extends through and along the axial length, or portions thereof, of the head **12** and neck **14**, or head **12**, neck **14** and base **16**. In yet another embodiment, the hollow-core **34** may be off-axis and/or non-parallel to the axial length of the device **10**.

The dental implant system of the present invention may also include a healing ball **40**, shown in FIG. 4, that can be either removably secured or permanently affixed to the universal implant abutment device **10**. The healing ball **40** may be made of a variety of materials and combination of materials including, but not limited to, medical grade polyethylene, high-density polyethylene, K-resin, plastics, ceramics, metals and metal-alloys. In general, the healing ball **40** may be made of any biocompatible, non-toxic (e.g., medical grade) material that permits proper functioning of the healing ball **40**. In another embodiment of the invention, the healing ball material may also include barium or similar elements that make the healing ball radiopaque.

Referring to FIG. 4, and in the embodiment depicted therein, the healing ball **40** includes a cylindrical lower por-



## 11

tion 42 and a spherical upper portion 44. Other healing ball configurations including, but not limited to, tooth-shaped, cone-shaped, box-shaped, donut-shaped, collar-shaped, cylindrical and spherical, may also be used with the dental implant system. In another embodiment (not shown), the healing ball 40 may include one or more small holes or recesses. These holes/recesses may function as gripping and/or anti-rotational/anti-torque features that are engaged when tightening, removing or repositioning the healing ball within the patient's mouth.

As shown in FIG. 4, and in the embodiment depicted therein, a hexagonal-shaped opening or bore 46 extends along the axial length of the lower portion 42 and partially along the corresponding axial length of the upper portion 44. The hexagonal shape of the bore 46 is used for illustration purposes and not meant to limit the invention. In general, a variety of bore shapes or configurations adapted to engage the head 12 of the implant abutment device 10 may be used with the healing ball 40 of the present invention.

In the embodiment depicted, a cylindrical bore or opening 48 lies adjacent to and is aligned along the same axis of the hexagonal bore 46. The diameter of the cylindrical opening 48 may be less than, equivalent to or greater than the diameter of the hexagonal bore 46. As will be described in further detail below, the cylindrical opening 48 forms a lumen through the healing ball 40, thereby enabling associated components, such as a guide pin, retaining screw, cement, wax and other components included within the scope of the claimed invention, to be inserted therethrough. In yet another embodiment (not shown), the opening 48 maybe off-axis and/or non-parallel to the axis of the device 10.

In an alternate embodiment, shown in FIG. 5, the cylindrical opening 48 is removed and the hexagonal bore 46 forms the entire opening or lumen through the healing ball 40. In another embodiment (not shown), the hexagonal bore 46 is removed and the cylindrical bore 48 forms the entire opening or lumen through the healing ball 40. For the sake of simplicity of representation, references to the bore 46 of the healing ball 40 in the remainder of this disclosure should be understood to include bore 46 and/or opening 48.

As previously described, the bore 46 of the healing ball 40 is configured to match and snugly fit over the hexagonal head 12 of the implant abutment device 10. As such, an octagonal opening in a healing ball 40 would be used for a device 10 having an octagonal head 12, a triangular bore 46 in a healing ball 40 would be used for a device 10 with a triangular head 12, and so on.

In another embodiment (not shown), a reverse configuration of the manner in which the device 10 and healing ball 40 engage each other is contemplated. For example, the device 10 may include a recess, bore or opening into which the healing ball's 40 mating shaft, post or protrusion is inserted. Other methods of engagement not specifically disclosed herein but known in the art are also comprehended.

In an alternate embodiment (not shown), the bore 46 is formed of two opposing flat surfaces or walls and two opposing arcuate surfaces or walls. The two flat surfaces of the healing ball 40 engage two of the main-walls 18 of the implant/abutment head 12 and the two arcuate surfaces engage the remaining main-walls 18.

Thus, in the embodiment depicted, the healing ball 40 engages the device head 12 in a manner similar to a conventional wrench-and-socket configuration. Alternate embodiments of the bore 46 including, but not limited to, cylindrical, spherical, stepped, cylindrically-tapered, off-axis, non-parallel and other configurations not specifically disclosed herein, are also included within the scope of the claimed invention.

## 12

In another embodiment of the healing ball 40, the axial length of the bore 46 is approximately equivalent to the height HY of the head 12 (shown in FIG. 1).

Alternatively, the length of the bore 46 may be greater than the height HY of the head 12. In one embodiment, the base 50 of the healing ball 40 surrounding the bore 46 rests upon the ledge 26 (see FIG. 1A) of the device 10, ensuring a proper fit within the patient's mouth. In another embodiment (not shown), the opening of the healing ball 40 includes an inwardly-extending annular protuberance which is adapted to fit within and is removably secured to a matching annular groove surrounding the device 10.

This configuration and other embodiments disclosed in U.S. Pat. No. 6,068,479 (of which the specification is incorporated herein by reference) or not specifically disclosed herein are also included within the scope of the claimed invention.

The healing ball 40 is but one of many types of dental copings which may be used with the device 10 of the present invention. Other types of dental copings and/or gold cylinders including, but not limited to, those disclosed in U.S. Pat. No. 6,068,479; U.S. Pat. No. 5,733,124; U.S. Pat. No. 5,613,854; U.S. Pat. No. 5,571,016; U.S. Pat. No. 5,439,380; U.S. Pat. No. 5,419,702; U.S. Pat. No. 5,213,502; U.S. Pat. No. 5,209,659; U.S. Pat. No. 5,145,371; U.S. Pat. No. 5,108,288; U.S. Pat. No. 5,040,983; U.S. Pat. No. 4,861,267; U.S. Pat. No. 4,797,100; U.S. Pat. No. 4,698,021; U.S. Pat. No. 4,676,751; U.S. Pat. No. 4,492,579; U.S. Pat. No. 4,459,112; U.S. Pat. No. 3,685,115; RE 33,796; RE 33,272; RE 33,099; and the like may also be used with the implant abutment device 10. The entire disclosure of each of these patents is hereby incorporated by reference into this specification.

In one embodiment of the present invention, the healing ball 40 may be removed from the implant abutment device 10 prior to attachment of the dental prosthesis. As such, the healing ball 40 may serve as a temporary cover to protect the patient's tongue, inner-cheek and/or inner-lips from contacting potentially rough or abrasive edges of the device 10. In addition, the healing ball 40 may also function as a tissue spacer, as described in further detail below. Guide pins, retaining screws, wax or other attachment devices or compounds, including various combinations thereof, may be used to temporarily attach the healing ball 40 to the device 10. Once the final prosthesis is available, the attachment device or compound and healing ball are removed and the prosthesis is secured to the implant abutment device 10 within the patient's mouth.

In another embodiment of the invention, the healing ball 40 may be permanently affixed to the device 10 so that the dental prosthesis directly attaches to the healing ball 40. For example, prostheses or dentures including metal rings, caps with rubber o-rings, ball attachment replicas and other similar fastening elements may be friction fit over the healing ball 40 to firmly, securely and removably attach the prosthesis to the implant abutment device 10. As shown in FIG. 6A, one or more healing ball 40 and implant abutment device 10 assemblies are secured within the patient's mouth. Attachment devices and compounds including, but not limited to, cement, retaining screws, glues, wax, permanent soft-liner materials (such as, for example, silicone or Coesofte) and other attachment devices and compounds, including combinations thereof, may be used to permanently secure the healing ball 40 onto the implant abutment device 10. The fastening elements 52 of the prosthesis 54 are then friction fit over the healing balls 40 to securely attach the prosthesis 54 within the patient's mouth.



13

In an alternate embodiment, one or more tooth-shaped healing balls **40** are permanently affixed to one or more devices **10** implanted within the patient's jawbone.

As shown in FIGS. **6A** and **6B**, a prosthesis, denture or partial-denture **55** including one or more retention clasps, rings or elements **57** aligned to engage the healing ball(s) **40** act as retaining elements to secure and stabilize the denture in the patient's mouth.

Alternate configurations of attaching the dental implant system of the present invention either removably or permanently to a prosthesis are well-known to those skilled in the art are also included within the scope of the present invention.

In another embodiment of the invention (not shown), bar-clip overdentures, crowns and/or bridges (such as those disclosed in U.S. Pat. No. 5,174,954, of which the entire disclosure is herein incorporated by reference) may be readily connected to either the healing ball **40** and implant abutment device assemblies or to the gold-cylinder and implant abutment device **10** assemblies. As will be apparent to those skilled in the art, the universality of the dental implant system of the present invention enables it to be used in conjunction with many different types of prosthetic applications. Further, it provides the dental practitioner with substantially more flexibility with reduced number of parts/components than the prior art systems.

Referring to FIG. **7**, the dental implant system may also include an abutment-analog **56**. The abutment-analog **56** is generally a replica of the head **12** and/or neck **14** of the implant abutment device **10** and mainly used in laboratory procedures during construction of patient models and prostheses. The abutment-analog includes a head **58** and neck **60** similar in design and configuration to the head **12** and neck **14** of the implant abutment device **10** previously described.

In one embodiment, the head **58** and neck **60** of the abutment-analog **56** are exact replicas of the head **12** and neck **14** of the implant abutment device **10**.

The abutment-analog **56** may be made from a variety of materials. Examples of such materials include, but are not limited to, brass, gold, titanium, stainless steel, metals, metal-alloys, ceramics, plastics, composites and combinations thereof are also included within the scope of the claimed invention.

As shown in FIG. **7**, the abutment-analog **56** also includes a shaft **62**. In one embodiment, the shaft **62** includes cylindrically shaped top **64**, middle **66** and bottom **67** portions. The diameter of each shaft portion **64**, **66**, **67** is variable, ranging in size from approximately 1.0 millimeter to 10.0 millimeters. For example, in one embodiment the top portion **64** is approximately 3.0 millimeters, the middle portion **66** is approximately 1.75 millimeters and the bottom portion **67** is approximately 3.0 millimeters. Alternatively, the top **64**, middle **66** and bottom **67** portions maybe approximately 1.0 millimeter, 3.0 millimeters and 1.0 millimeter, respectively. In general, the shaft **62** may be configured with various gripping surfaces, projections, indentations, flat/planar portions and non-planar portions to prevent the abutment-analog **56** from becoming dislodged from or rotating around the rigid stone or plaster material that forms the final model for the prosthesis, as described in further detail below.

Referring to FIGS. **8** and **9**, the dental implant system of the present invention may also include a retaining screw **68** and guide pin **70**, respectively. Referring to FIG. **8**, the retaining screw **68** is used to secure the healing ball **40** and/or prosthesis, either permanently or temporarily, onto the implant abutment device **10**.

As such, the threaded portion **72** of the retaining screw **68** is configured to engage the threads on the surface of the

14

internal walls **36** of the device **10**. In general, the retaining screw may be approximately 2.0 millimeters to 10.0 millimeters in length. In one embodiment, the diameter of the head **74** of the retaining screw **68** may be configured to seat within the lumen of the healing ball **40**. Alternatively, the head **74** may be seated on the external surface of the healing ball **40**. The retaining screw **68** may be made of a variety of biocompatible, non-toxic materials including, but not limited to, brass, gold, titanium, stainless steel, metals, metal-alloys, ceramics, plastics, composites and combinations thereof.

The guide pin **70**, shown in FIG. **9**, is used to secure the healing ball **40** to the implant abutment device **10** for taking final impressions of the position of the head **12** of the device **10**. The length of the guide pin **70** is approximately within the range of 3.0 millimeters to 20.0 millimeters. In general, the guide pin **70** is configured so that a sufficient portion of the head or shaft **76** extends outside of the healing ball **40**, enabling a user or practitioner to firmly and securely grip the guide pin **70**. The shaft **76** may be made of a variety of shapes and surface configurations including, but not limited to, cylindrical, conical, polygonal, ribbed, dimpled, smooth and textured.

As with the retaining screw **68**, the threaded portion **78** of the guide pin **70** may also be configured to engage the threads on the surface of the internal walls **36** of the device **10**. In addition, a variety of biocompatible, non-toxic materials may be used to fabricate the guide pin **70** of the present invention. Examples of these materials include, but are not limited to, brass, gold, titanium, stainless steel, metals, metal alloys, ceramics plastics, composites and combinations thereof are also included within the scope of the claimed invention.

Although the retaining screw **68** and guide pin **70** are shown in FIGS. **8** and **9**, respectively, to include a slotted head, other head configurations known in the art to either manually or mechanically drive the screw **68**/guide pin **70** into the device **10** may also be used and are included within the scope of the claimed invention. One or more of the universal implant abutment device **10**, healing ball **40**, abutment-analog **56**, guide pin **70** and retaining screw **68** components of the dental implant system of the present invention may be packaged together to form a kit (not shown). The size, material, shape and configuration of each component compliments the other components, thereby assuring compatibility, interchangeability, durability and perfect fit. In addition, component parameters, such as size, material, shape and configuration of each component for either single or multiple tooth replacement kits, may be the same or variable within each kit.

Each kit may be configured to provide the necessary components for a particular procedure. For example, in one embodiment of the invention, the kit for a single-tooth replacement procedure may include one implant abutment device **10**, three healing balls **40**, one abutment-analog **56**, one retaining screw **68** and one guide pin **70**. In another embodiment, a single-tooth replacement kit may include two implant abutment devices **10**, six healing balls **40**, two abutment-analogs **56**, two retaining screws **68** and two guide pins **70**. In an alternate embodiment, a multiple-tooth replacement kit may include three implant abutment devices **10**, nine healing balls **40**, three abutment-analogs **56**, three retaining screws **68** and three guide pins **70**. Other kit configurations not disclosed herein but known in the art are also included within the scope of the claimed invention.

Many methods of using the universal implant system of the present invention are contemplated herein. Each methodology is related to the particular type of dental reconstruction required by the patient's condition. The following methods



## 15

are intended as examples and for illustration purposes only and are not meant to limit the claimed invention.

In one embodiment, a mid-crestal and reverse bevel labial incision **80** is made extending along two teeth and on both sides of the edentulous space, as shown in FIG. **10**. A similar incision is made palatally, resulting in a full thickness envelope flap **82** as shown in FIG. **11**.

Referring to FIG. **12**, a hole **84** is then drilled within the jawbone of the patient. The exact point of purchase and approach, either cingulum or labial, within the edentulous space and jaw anatomy are visually determined. In general, the approach should be one that will provide the greatest amount of stability for the device **10**, and, generally, is parallel to the long axis of adjacent teeth.

One or more drill bits used at variable speeds with sufficient irrigation create the appropriately sized and shaped hole **84**. The depth of the hole **84** is sized to receive the base **16** of the implant abutment device **10**, and generally ranges from approximately 8 millimeters to 30 millimeters in depth.

Referring to FIG. **13**, the implant abutment device **10** is then manually inserted into the hole **84** in a sterile manner. In one embodiment, a carrier (not shown) may be used to deliver the implant abutment device **10** to the hole **84** and also to begin manually screwing the device **10** into the hole **84**. An example of such a carrier is disclosed in U.S. Pat. No. 6,068, 479, of which the entire disclosure is incorporated herein by reference. Other carriers and similar tools not specifically disclosed herein but known in the art may also be used and are included within the scope of the claimed invention.

Generally, only a portion of the base **16** of the implant abutment device **10** can be manually inserted into the hole **84**. A power-driven socket-wrench, contra-angle handpiece or similar tool may be used to fully seat the device **10** within the hole **84**.

Crestal bone height and clinical parameters such as device stability, tissue thickness as required for prosthesis aesthetics and inter-occlusal distance may also be taken into consideration to determine final position and configuration of the device **10**.

The gingival tissue and flaps **82** are inspected, trimmed, coapted and sutured around the head **12** of the device **10**. Factors, such as amount of tissue recession after healing, final crown space required and/or other aesthetic and prosthetic considerations, may be taken into account with respect to tissue placement and suturing.

Either immediately after suturing or anytime thereafter, the prosthesis may be attached to the device **10**. No further surgical procedures are required, unlike prior art processes which often require a second stage surgery to expose and prepare a gingival seat around the device and perform other modifications to ensure proper prosthetic-device engagement. As previously described, with prior art devices and procedures, a space or recess between the device and soft tissue must be created to allow an appropriate interface and ensure proper placement of the prosthesis without trapping soft tissue. In contrast, the prosthesis may be directly attached to the implant abutment device **10** of the present invention without further surgical intervention.

Referring to FIG. **14**, a healing ball **40** may be attached to the device **10** to contour the tissue for proper impression registration. In one embodiment of the invention, the healing ball **40** is attached directly after tissue suturing and prior to hard and soft tissue healing. A retaining screw **68** or similar component previously described may be used to secure the healing ball **40** onto the device **10**. The healing ball **40** is then left in place for an approximately seven to ten day time period.

## 16

Alternate time periods that allow the soft tissue to mature and form a stable recess for the prosthesis may also be used.

After the soft tissue has matured and formed a stable recess, a final impression may be taken from which the prosthesis is created. The original healing ball **40** is removed, and another, interchangeable healing ball **40** is secured to the device **10** with a guide pin **70**. Alternatively, the original healing ball **40** is left in place and the retaining screw **68** is replaced with a guide pin **70**.

As shown in FIG. **15**, an impression tray **86** with a window or opening **88** is placed over the healing ball **40** within the patient's mouth. The opening **88** of the tray **86** is aligned with the guide pin **70** so that the guide pin **70** protrudes above the impression frame. The guide pin **70** holds the healing ball **40** in place during setting of the impression material. After the material is set, the protruding portion of the guide pin **70** is used to unscrew the guide pin **70** from the healing ball **40** and remove the guide pin **70** through the tray opening **88**. The healing ball **40** is then transferred with the impression material when the impression tray **86** is removed from the patient's mouth, as shown in FIG. **16**. The original healing ball **40** may be re-attached to the device **10** as a protective covering and tissue spacer.

In an alternate embodiment, anti-rotational grooves, indentations or other types of gripping features may be formed on the healing ball **40**. These features prevent movement or displacement of the healing ball **40** within the impression material when the healing ball **40** and impression tray are removed from the patient's mouth.

Referring to FIG. **17**, and in the process depicted therein, an abutment-analog **56** is inserted into the matching cavity of the healing ball **40** contained within the impression material. As previously described, the abutment-analog **56** replicates the configuration of the implant abutment device **10** of the present invention. With the abutment-analog **56** seated in the healing ball **40**, an impression is then poured in a rigid stone or plaster material to form the final model **90**. In general, the entire abutment-analog **56**, excluding its head **58** or head **58** and neck **60**, may be buried in the final working model **90**. As such, the remaining exposed portion of the abutment-analog **56**, together with the impression material, forms an accurate and visible replica of the edentulous space within the patient's mouth prior to restoration, as shown in FIG. **18**.

Referring to FIG. **19**, a healing ball **40**, coping (such as a preformed coping in the shape of a healing ball **40**, tooth or other shapes) or metal framework may be used as part of the final prosthesis **92**. Some of the materials used to form the final prosthesis include, but are not limited to, metal, metal alloys, ceramics, composites, aluminum oxide, fiber core, zirconium and other materials. The final prosthesis **92** may be formed using a lost wax technique, laser scan generated images, optical impression, CAD/CAM manufacturing, reverse engineering, rapid prototyping and other conventional techniques or methods. Once complete, the final prosthesis **92** is then installed within the patient's mouth using cement, retaining screws, or other attachment means known to those skilled in the art.

In an alternate embodiment (not shown), two or more implant abutment devices **10** may be used for a single tooth (e.g., molar) restoration. The use of multiple implant abutment devices **10** for a single tooth restoration provides greater support and stability for the final prosthesis. In addition, this configuration provides improved osseointegration and greater device surface area, which also improves the retentive strength of the prosthesis.

A multiple tooth or full-mouth reconstruction method of the present invention is similar to the single tooth reconstruction



tion method. However, as previously described, multiple tooth or full-mouth reconstruction procedures are more involved, requiring common paths of insertion, sufficient friction to ensure a firm fit and no undue soft tissue tension.

In one embodiment, the incision **80**, hole **84** and implant abutment device **10** insertion are made in a manner similar to that previously described for the single tooth reconstruction method. However, the approach is modified to accommodate multiple restorations. For example, the incision **80** may be larger, multiple holes **84** are generally created within the jawbone of the patient, and, likewise, multiple implant abutment devices **10** are inserted within the holes **84**, as generally shown in FIG. **20**. The four-teeth reconstruction shown in FIG. **20** is for illustration purposes and not meant to limit the scope of the claimed invention.

After adequate soft tissue healing has occurred and a stable recess for the prosthesis has been formed using healing balls **40** as previously described, the temporary prosthesis or original healing balls **40** are removed from each device **10**.

In one embodiment, a pattern resin or similar material may be used to lute or connect all the healing balls **40** together as one unit, forming a coping framework. This process may be used for both the original healing balls **40** and the new healing balls **40**.

Next, an impression is taken using an appropriately sized impression tray **86**.

The protruding portions of the guide pins **70** extend through the opening(s) **88** in the impression framework, as shown in FIG. **21**. Alternatively, a traditional disposable stock tray (not shown) may be used. As such, after all the healing balls **40** are luted or splinted together thereby forming a "picket-fence" type effect, the guide pins **70** can be removed from the healing balls **40**. The healing balls **40** will remain in position and form in a stable framework due to the "picket-fence" effect and remain in proper alignment with each other. Impression material can then be injected under and around the healing balls **40**.

After the impression material has set, the guide pins **70**, tray **86** and impression material are removed from the patient's mouth. The resulting impression includes the healing balls **40** incorporated in the impression material. The low height or minimal profile of the head **12** of each device **10** and flexibility of the impression media allow an accurate impression to be made, without permanent distortion or damage. In particular, the healing balls **40**, as integral parts of the impression, may be cleanly withdrawn from the devices **10** without disturbing the precise relationship of each reference device **99**. The other devices **10** are then modified (e.g. portion **100**, shown in the FIG. **24** as encircled by a dashed line, is removed) according to the inclination/alignment of these devices **10** in relationship to the reference device **99** to ensure a secure and accurate fit for the final prosthesis.

Healing balls **40**, copings or metal frameworks are then installed on the modified heads **58** of the stone model **94** and may be used as part of the final prosthesis. As previously described, the final prosthesis may be formed using a lost wax technique, laser scan generated images, optical impression, CAD/CAM manufacturing, reverse engineering, rapid prototyping and other conventional techniques or methods.

With the final stone model **94** as a guide, the corresponding surfaces of the device heads **12** in the patient's mouth are removed. After a passive placement is achieved, the final prosthesis is then installed using cement, retaining screws or other attachment means to stabilize and secure the prosthesis within the patient's mouth.

In an alternate embodiment of the invention, a template (not shown) together with the final stone model **94** is used as

a guide for removing the necessary portions/surfaces of the device heads **12** in the patient's mouth. The template may be one or more copings, caps, framework or other types of coverings linked or connected together to maintain alignment of the caps to each other and to their counter-part abutment-analog **56** in the final stone model **94**. The template may be made of a variety of materials including, but not limited to, metals, metal alloys, plastics, ceramics, composites and other materials, including combinations of materials.

Further, each cap may be a variety of configurations (such as, for example, cylindrical, spherical, hexagonal, polygonal and other configurations), provided the cap configuration matches to securely engage its corresponding analog-abutment configuration.

The following example and associated figures will reference only a single cap in a template and a single abutment-analog **56** in a final stone model **94**, however it is understood that the template and final stone model **94** include one or more caps and abutment-analog **56**, respectively.

As previously disclosed, the cap of the template replicates its counterpart head **58** of the abutment-analog **56** in the final stone model **94**. Referring to FIG. **25**, a portion **100** (shown in phantom on FIG. **25**) of the analog-abutment head **58** in the final stone model **94** is removed or modified as previously described. The corresponding portions of its matching cap **102** are then also removed, forming a window or some other type of opening **104** in the cap **102** that corresponds to the modified area of the head **58**, shown in FIG. **26**.

As shown in FIG. **27**, when the cap **102** is properly positioned or placed over the patient's corresponding implant abutment device **10**, portions of the device **10** protruding through the opening **104** correspond to the removed portions of the analog abutment **56**. At this point, the user may use an appropriate tool to remove the protruding portions of the device **10**. Alternatively, the user may simply mark the portions of the device **10** that need to be modified, remove the cap and then remove/modify the marked portions of the device **10**. Other methods of modifying the device **10**, including the cap **102**, not specifically disclosed but known in the art may also be used.

The quantity of components and associated reconstruction methods of the dental implant system of the present invention are greatly reduced and simplified compared to conventional implant systems and methods of use. Especially in multiple implant situations, the dental implant system of the present invention greatly reduces the number of clinical procedures and total treatment time. In particular, the amount of time between the initial surgery to the tooth/prosthesis mounting is greatly reduced.

Further, the procedures or methods of the present invention are also more predictable with respect to cosmetic and functional effects of the final prosthesis when compared to traditional approaches. As such, the dental implant system of the present invention may reduce post-operative infection, improve device/prosthesis strength and prolong its stability and reduce the overall time for a reconstruction procedure by approximately three months or more. In addition, the dental implant system and associated methods of the present invention enable a practitioner to form a final prosthesis, including an infinite number of facsimiles of said final prosthesis (for example, as spares or replacements if the original prosthesis should become damaged or lost), based on a single impression. In general, the overall procedure using the dental implant system of the present invention is fast, simple and effective.



19

FIG. 28 is a partial exploded view of a dental implant assembly 200 comprised of a head 202 which facilitates the use of assembly 200 in multiple implant restorations.

Referring to FIG. 28, and in the embodiment depicted therein, it will be seen that head 202 is comprised of sides 204, 206, 208, 210, and 212. Each of these sides intersects with surface 214 of neck 14. In another embodiment, not shown, no neck section is present and the aforementioned sides meet directly with base 16.

In one embodiment, illustrated in FIGS. 34A and 34B, the neck 14 is omitted and the head 202 is directly contiguous with base 16. In the embodiment depicted in FIGS. 34A and 34B, the head section is substantially smaller than the base section, and thus a ledge is created at the neck section. In the embodiment depicted in FIG. 34C and FIG. 34D, the head section is substantially the same size as the base section, and thus no ledge is created.

Referring again to FIG. 28, and in the embodiment depicted therein, with the exception of side 208, each of the other sides forms an angle vis-a-vis surface 214 that is substantially perpendicular, ranging from about 80 to about 100 degrees and, more preferably, from about 75 to about 95 degrees. However, the side 208 forms an angle with surface 214 of less than about 75 degrees.

In the embodiment depicted in FIG. 28, there are at least five sides that intersect surface 214 at a substantially perpendicular angle. Devices with more of such sides may be used, provided that at least two sides of the head 202 are substantially perpendicular to the surface 214 and at least one side forms an angle with such surface of less than about 75 degrees. In one embodiment, at least three such sides of the head 202 are substantially perpendicular to the surface 214. In another embodiment, at least four such sides of the head 202 are substantially perpendicular to the surface 214. In yet another embodiment, at least five such sides of the head 202 are substantially perpendicular to the surface 214.

In another embodiment, depicted in FIG. 28C, at least two of sides of the head 202 form an angle of from about 45 to about 100 degrees with the surface 214 and the abutment head is comprised of a linear wall joined to an accurate wall.

Referring again to FIG. 28, a bore 216 extends from the top surface of the head 202 to a distance of from about 2 to about 5 millimeters. In one embodiment, the bore 216 is threaded.

In another embodiment, not shown, the bore 216 is omitted from the head 202. In another embodiment, not shown, the bore 216 is replaced by an annular groove disposed beneath substantially polygonal portion of head 202 and surface 214. In one embodiment, the bore 216 is substantially coaxial with the axis 220 of base 16. In another embodiment, illustrated in FIG. 28, the bore 216 is not coaxial with the axis 220 but, instead, forms an angle that is less than 45 degrees and, in one embodiment, is substantially identical to the angle formed by side 208 with surface 214.

FIGS. 28A and 29A disclose a dental implant assembly 201 which is similar to the assembly 200 but differs therefrom in that the bore 216 is substantially perpendicular to the axis 220.

FIGS. 28B and 29B disclose a dental implant assembly 203 which is similar to the assembly 200 but differs therefrom in that the bore 216 is substantially parallel to the axis 220. In the embodiment depicted, bore 216 is also substantially coincident with the axis 220.

Referring again to FIG. 28, it will be seen that a healing ball 205 is adapted to fit over the head 202. A similar healing ball 205 may be used in the embodiments depicted in FIGS. 28A and 28B but has been omitted therefrom for the sake of simplicity of representation.

20

The shape of the head depicted in FIGS. 29A and 29B may be varied. Some other suitable shapes are depicted in FIGS. 30A through 30H.

FIGS. 30A through 30H present a multiplicity of sectional views showing the shapes in which the head 202 may be. In the embodiments depicted, the shapes are either comprised of straight walls 230 and/or arcuate sections 232.

FIGS. 31A and 31B are perspective and top views, respectively, of an assembly 240 in which arcuate section 242 joins walls 244 and 246 (see, for example FIG. 31A) of inclined side 208. As will be apparent, because arcuate section 242 theoretically contains an infinite number of walls, the assembly 240 meets the requirement that at least two such walls are substantially perpendicular to the surface 214 of base 16. In another embodiment, the walls are at an angle of from about 45 to about 95 degrees relative to surface 214. In the embodiments depicted, wall 242 and 208 extend downwardly and outwardly.

FIG. 32 discloses an exploded view of an assembly 250 that is similar in configuration to the assembly 240 but differs therefrom in that arcuate section 242 is comprised of a multiplicity of splines 252. In the configuration depicted in FIG. 32, such splines 252 have a substantially rectangular cross-sectional shape.

Referring again to FIG. 32, and in the embodiment depicted therein, it will be seen that healing ball 205 preferably is comprised of an orifice 256 that is adapted to receive the side 208 and the splines 252.

FIG. 32A is a partial sectional view of an implant assembly 207 that is similar to the implant assembly 201 (see FIG. 28A) but omits that omits the bore 216.

FIG. 32B is a partial sectional view of an implant assembly 209 that is similar to the implant assembly 201 (see FIG. 28A) but differs therefrom in that it does contain a bore 216 that is substantially aligned with the axis of the assembly 209.

As will be apparent from FIGS. 33A through 33H, different splined arrangements may be used with the assembly 250.

Thus, as depicted in FIG. 33A, the splines 252 may have a substantially rectilinear cross-sectional shape. As depicted in FIG. 33B, the splines 256 may have a substantially triangular cross-sectional shape. As depicted in FIG. 33C, the splines 258 may have a substantially circular cross-sectional shape. As depicted in FIG. 33D, the splines 260 may have a substantially polygonal cross-sectional; in the embodiment, depicted, this shape is formed by alternating rectangles and triangles. As depicted in FIG. 33E, the splines 262 may have a shape defined by a linear section and an arcuate section; in the embodiment depicted, the splines 262 are formed by alternating semicircles and flat surfaces. As depicted in FIG. 33F, the splines 264 may have different shapes which may alternate on the splined surface; thus, e.g., they may contain both triangular, circular, and composite shapes in which flat top intersects two adjacent splines. The splines 266 depicted in FIG. 33G are defined by half-circles joined by arcuate tops. By comparison, the splines 268 depicted in FIG. 33H are defined by triangular sections joined by arcuate tops. Many other splined shapes, not shown, also may be used. All of the aforementioned walls can be substantial perpendicular or, in other embodiments, form an angle from 45 to 95 degrees relative to the center axis. In one embodiment, such an angle is formed between the walls and the neck. In another embodiment, no neck is present and such an angle is formed between the walls and the base.

FIG. 35 is a perspective view of an implant assembly 270 that is similar to the implant assembly 269 of FIGS. 34A and 34B but differs therefrom in that the surface 272 of base 16 is roughened.



In one embodiment, the surface **272** is roughened in accordance with the acid-etching procedure disclosed in International patent publication W09616611A2. In the process described in this patent publication, the surfaces of the implant body are exposed to an acidic etching process after the natural titanium oxide layer is removed to attain an essentially uniform roughness over the entire surface (W09616611A2). Reference may also be had to applicant's U.S. Pat. No. 5,733,124, the entire disclosure of which is hereby incorporated by reference into this specification.

In another embodiment, the surface **272** is roughened in accordance with the procedure disclosed in an article by Cochran et al., "Bone response to unloaded and loaded titanium implants with a sand-blasted and acid-etched surface", Journal of Biomedical Materials Research, Vol. 40, 1998, p. I. In this process, the surface **272** is subjected to coarse sand blasting to create macro-roughness in the titanium. This process is followed by acid etching that generates evenly-distributed micro-pits in the sand-blasted surface.

One may roughen such surface **272**, or other surfaces, by conventional means known to those skilled in the art. Thus, e.g., one may use the roughening processes disclosed in U.S. Pat. No. 5,588,838 of Hannson (micro-roughness having a height between 0.02 millimeters to about 0.2 millimeters); U.S. Pat. No. 5,607,480 of Beaty (individual depressions and dents with transverse dimensions about half of the size of impacting grit particles, on the order of 5-10 microns); U.S. Pat. No. 5,947,735 (additive and subtractive roughening); U.S. Pat. No. 5,897,319 of Wagner et al. (surface roughness of from about 7 to about 300 microinches); U.S. Pat. No. 6,344,061 of Leitao et al. (surface roughness with an average peak distance between 10 and 1,000 nanometers); U.S. Pat. No. 6,095,817 of Wagner et al., and the like. The entire disclosure of each of these United States patents is hereby incorporated by reference into this specification.

One means for providing the desired degree(s) of roughness to the implant assembly of this invention is described below. The process described below is especially advantageous for use with one-piece implant assemblies.

In this process, all abutment areas are preferably completely covered by soft wax to get a demarcation and to protect the abutment portion of the one piece implant from sandblasting and etching.

Waxing of the implant abutment assembly involves insertion of a guide pin into bore **216** (see FIG. **36**). The implant assembly is then placed into a pre-drilled Pro-form laminate plate. Wax is then heated on a hot plate to a temperature sufficient to melt the wax and liquefy it.

A masking device, such as a plate, is used to separate and isolate the top part of the implant assembly from its bottom part. The plate is preheated to a temperature of about 70 degrees Centigrade for about 10 minutes. Thereafter, wax is poured over the masked implant assembly and allowed to cool for from about 30 to about 45 minutes. Thereafter, the assembly is cooled in a refrigerator for from about 10 to about 15 minutes. The partially masked implant assembly that is partially embedded in wax is then subjected to sandblasting.

Thereafter the exposed portion(s) of the one-piece implant assembly is grit blasted using a Renfert sandblaster with non-recycled aluminum oxide (50 micron size) to remove burrs and metallic contaminants. The sand-blasted assembly is then subjected to acid etching.

In one embodiment, acid etching is accomplished with the use of an acid solution composed of a 10-30 volume percent (150-450 g/l) of 70% nitric acid and 1:3 volume percent (12 to 36 g/l) of 48% hydrofluoric acid (maintaining a ratio of 10 parts nitric acid to 1 part hydrofluoric acid). The surface of the

implant assembly to be acid etched is contacted with the acid mixture while being subjected to ultrasonic energy for 3 minutes.

FIGS. **37A** and **37B** illustrate two devices which may be made by the process of this invention. Referring to these Figures, it will be seen that each of implant assemblies **300** and **302** is comprised of base section **304**, and ledge section **320**, and head section **308**.

In each of implant assemblies **300** and **302**, the base section **304**, the ledge section **320**, and the head section **308** are integrally joined to each other.

In each of implant assemblies **300** and **302**, the head section **308** has a cross-sectional shape formed by alternating arcuate and linear walls; similar devices are disclosed in U.S. Pat. No. 5,733,124, the entire disclosure of which is hereby incorporated by reference into this specification. Referring to implant assembly **300**, one of the linear walls is linear wall **301**, and the arcuate walls are arcuate walls **303** and **305**.

Referring to implant assembly **302**, the linear wall is linear wall **307**, and the arcuate wall is arcuate wall **309**.

Each of implant assemblies **300** and **302** is comprised of a base section **304** that extends upwardly and outwardly from its bottom **310** to its top **312**.

In the embodiments depicted in FIGS. **37A** and **37B**, the base section **304** is preferably comprised of two distinct sections. The first section **313**, extending from point **314** to point **316**, has a length **318** of from about 3 to about 50 millimeters and, preferably, from about 7 to about 17 millimeters. The second section is ledge section **320**, extending from point **314** to point **322**, has a length **324** of from about 0.0 to about 2 millimeters and, preferably, from about 0.3 to about 0.7 millimeters.

It is advantageous that ledge section **320** have a length **324** that is no greater than about 15 percent of the length **318** of first section **313** and, more preferably, is less than about 10 percent of the length **318** of first section **313**.

In both of the embodiments depicted in FIGS. **37A** and **37B**, the first section **313** has a substantially rougher surface than the ledge section **320**.

FIG. **38** is a sectional view of a roughened surface **350** formed in a substrate **352**. As will be seen, this roughened surface **350** is comprised of a multiplicity of peaks **354** and valleys **356**. The distances **360**, **362**, **364**, **366**, **368** between the peaks **354** and the valleys **356** indicate the roughness of surface **350**. For the purposes of this specification, the roughness of any such surface is the average peak-to-valley distance of the surface. As is known to those skilled in the art, this may be measured by conventional techniques, such as, e.g., scanning electron micrography.

Referring again to FIGS. **37A** and **37B**, and in the embodiment depicted therein, the first section **313** will preferably have an average roughness (i.e., an average peak to valley distance of its indentations) of from about 0.3 microns to about 1,000 microns. In another embodiment, the average roughness is from about 10 to about 1,000 microns and, preferably, from about 20 to about 200 microns. In another embodiment, the average roughness is from about 0.3 microns to about 10 microns.

In this embodiment, the ledge section **320** will preferably have an average roughness (i.e., an average peak to valley distance of its indentations) of from about 0.1 to about 100 microns.

The first section **313** will preferably have an average roughness that is at least about 10 times as great as the average roughness of the ledge section **320**. In one embodiment, the first section **313** has an average roughness that is at least about 50 times as great as the average roughness of ledge section



**320.** In another embodiment, the first section **313** has an average roughness that is at least about 100 times as great as the average roughness of ledge section **320**.

One may obtain the differential roughness properties described hereinabove by subjecting the first section **313** and/or ledge section **320** to different treatments and/or different lengths of treatment, masking one (with wax, e.g.) while treating another. Thus, for example, the first section **313** may be treated with both sandblasting and acid etching, whereas the ledge section **320** may be subjected to micromachining or laser etching.

Thus, e.g., one may use microtexturing to create the roughness in ledge section **320**. Reference may be had, e.g., to U.S. Pat. Nos. 6,228,434; 5,964,804; 5,782,912; 5,349,503; 5,909,020; and the like. The entire disclosure of each of these United States patents is hereby incorporated by reference into this specification.

Thus, e.g., one may use laser etching to create the roughness in ledge section **320**. Reference may be had, e.g., to U.S. Pat. Nos. 5,164,324; 6,391,212; 6,277,312; 5,544,775; 5,018,164; and the like. The entire disclosure of each of these United States patents is hereby incorporated by reference into this specification.

In one embodiment, illustrated in FIGS. **37A** and **37B**, the roughened first section **313** is coated with a bioactive coating **370**. The bioactive coating **370** is comprised of or consists essentially of a biological active material.

As is disclosed in U.S. Pat. No. 6,344,061, the substrate having the desired surface roughness can efficiently be coated in vitro with a layer of one or more biologically active agents; the entire disclosure of this United States patent is hereby incorporated by reference into this specification. The composite coating can be relatively thin, in the order of from, e.g. 50 nanometers to 200 microns, especially from 1 to 50 microns. The biologically active agent in the coating includes, but is not limited to, single or combinations of proteins, lipids, (lipo)polysaccharides, growth-factors, cytostatic agents, hormones, and antibiotics. Examples of such agents are bone morphogenetic proteins (BMP's), basic fibroblast growth factor (bFGF), transforming growth factor (TGF-13), osteogenic growth peptide (OGP), and the like. The molecular weight of said biologically active agents can vary from several tens of Daltons, to thousands of kilo-Daltons. Reference may be had to U.S. Pat. No. 5,935,594 to Ringeisen (Process and Device for treating and healing issue deficiency); U.S. Pat. No. 6,949,251 to Dalal (Porous 13-tricalcium phosphate granules for regeneration of bone tissue); U.S. Pat. No. 6,902,721 to Mundy (Inhibitors of proteasomal Activity for Stimulating Bone Growth); U.S. Pat. No. 6,302,913 to Ripamonti (Biomaterial and Bone Implant for Bone Repair and Replacement); U.S. Pat. No. 6,139,585 to Li (Bioactive Ceramic Coating and Method); U.S. Pat. No. 6,080,799 to Gasper (Compositions and Methods for Stimulating Bone Growth); U.S. Pat. No. 5,944,524 to Hill (Biohybrid Dental Implant); and the like. The term "bone morphogenetic protein" is known to those skilled in the art. For example, reference may be had to the claims of U.S. Pat. No. 5,661,007 to Wozney (Bone morphogenetic protein-11 (BMP-11) compositions); U.S. Pat. No. 5,661,007 to Wozney (Bone morphogenetic protein-9 compositions), and the like. The term "basic fibroblast growth factor" is likewise known in the art. Reference may be made to the claims of U.S. Pat. No. 4,785,079 to Gospodarowicz (Isolation of fibroblast growth factor) and the like. The term "transforming growth factor" is defined in the claims of U.S. Pat. No. 5,278,145 to Keller (Method for protecting bone marrow against chemotherapeutic drugs using transforming growth factor beta 1) and the like. The

term "osteogenic growth peptide" is also known in the art. Reference may be had to the claims of U.S. Pat. No. 5,814,610 to Bab (Osteogenic growth oligopeptides and pharmaceutical compositions containing them); U.S. Pat. No. 6,593,394 to Li (Bioactive and osteoporotic bone cement). The content of each of the aforementioned patents is hereby incorporated by reference into, this specification.

In one embodiment, at least a portion of the coated layer has a thickness greater than the average depth of the roughened surface. See, e.g., U.S. Pat. No. 6,344,061. In another embodiment, the biologically active agent is selected from the group consisting of proteins, lipids, (lipo)polysaccharides, growth factors, cytostatic agents, hormones, antibiotics, hydroxyapatite and combinations thereof. See the aforementioned U.S. Pat. No. 6,344,061.

In yet another embodiment, the biologically active agent is selected from the group consisting of bone morphogenetic proteins, basic fibroblast growth factor, transforming growth factor, osteogenic growth peptide, and combinations thereof. See U.S. Pat. No. 6,344,061.

In one embodiment, the coating is comprised of one or more anions selected from the group consisting of hydroxide, chloride, sulphate, nitrate, and combinations thereof. In another embodiment, the coating further comprises one or more cations selected from the group consisting of hydrogen, sodium, potassium, magnesium, and combinations thereof. See, for example, the aforementioned U.S. Pat. No. 6,344,061.

In yet another embodiment, the sandblasting step is replaced by blasting with other abrasive material, such as alumina.

In yet another embodiment, the biologically active material is comprised of organic material comprising a multiplicity of amino acids and/or proteins.

In one embodiment, the organic material is an organic amine containing from about 1 to about 10 carbon atoms and from about 1 to about 4 amino groups. Some suitable materials in this embodiment include gamma-aminopropylethoxysilane, allyl amine, carbodimide, bone morphogenic protein, extracellular matrix proteins, and the like. Reference may be had, e.g., to articles by Wojcik et al. ("Biochemical surface modification . . . for the delivery of protein . . .," Biomed Sc Instrum 1997; 33: 166-171), by Puleo et al. ("A technique to immobile bioactive proteins . . .," Biomaterials 2002 May; 23(9): 2079-2087), by An et al. ("Prevention of bacterial adherence to implant surfaces . . .," J Orthop Res 1996 September; 14(5):846-849), by Bessho et al. ("BMP stimulation of bone response . . .," Clin Oral Implants Res 1999 June; 10(3):212-8), by Deligianni et al. ("Effect of surface roughness of the titanium alloy . . .," Biomaterials 2002 June; 22(11): 1241-1251), by Dean et al. ("Fibronectin and laminin enhance gingival cell attachment . . .," Int J. Oral Maxillofac Implants 1995 November-December; 10(6):721-728), by Keogh et al. ("Albumin binding surfaces for biomaterials," J Lab Clin Med 1994 October; 124(4):537-545), and the like. The disclosure of each of these publications is hereby incorporated by reference into this specification.

In one embodiment, the biologically active material is coated onto a relatively smooth first section **313** and/or ledge section **320** in order to form the roughened surface. As will be apparent, either the roughed surface, and/or the coated surface, will tend to promote adhesion between the implant assembly and the biological tissue surrounding it.

One means of facilitating such adhesion is to impart a charge to one or more of the implant surfaces. Thus, e.g., one may incorporate anions and/or cations into or onto such surface, as is disclosed in such U.S. Pat. No. 6,344,061. Thus,



25

e.g., one may incorporate charged moieties into or onto such surface by the process disclosed in an article by P. S. Chock-alinagm et al. entitled "DNA affinity chromatography," J. Mol Biotechnology 2001 October 19(2): 189-199.

In one embodiment, protein is coupled to silanized titanium with glutaraldehyde. See, e.g., the article by Wojcik et al., "Biochemical surface modification . . .," Biomed Sci Instrum 1997; 33: 166-171. Referring again to FIGS. 37A and 37B, and in the embodiments depicted therein, it will be seen that head section 308 extends a length 323 above the top surface 325 of ledge section 320 of from about 1.5 to about 10 millimeters and, preferably, from about 2 to about 4 millimeters.

The implant assembly of this invention may be used in the process disclosed in U.S. Pat. No. 6,068,479 and, in particular, in the FIG. 18 depicted therein; the entire disclosure of such U.S. Pat. No. 6,048,479 is hereby incorporated by reference into this specification.

Thus, e.g., referring to such U.S. Pat. No. 6,048,479 and, in particular, to the FIG. 18 thereof, in the first step of this process, step 300, device 10 is connected to an implant fixture.

In this step, it is advantageous to apply a torque no greater than about 20 Newton per centimeter.

Thereafter, in step 302 of the process, a hole is drilled in the jawbone of the patient sufficiently deep to receive only the length of the implant fixture. In general, this hole is usually from about 8 to about 18 millimeters.

Thereafter, in step 304 of the process, the hole thus drilled is preferably tapped with a tapping tool such as, e.g., the screw taps illustrated on page 11 of the Nobelpharma catalog.

Thereafter, in step 306 of the process, the abutment/implant fixture assembly is delivered to the hole by means of the carrier (for example, final model 90). The carrier may also be used to start screwing the assembly into the hole, applying downward pressure while turning the assembly. Generally, the carrier will only enable one to drive the abutment/implant fixture assembly a portion of the required distance. The job may be finished by a power-driven socket wrench in step 308 of the process.

In the next step of this process, step 310, the healing ball is preferably snapped onto the device 10. In one embodiment, the healing ball is disposed within a compartment of carrier prior to its use.

Thereafter, in step 312, the gum tissue where the hole had been drilled is sutured around the healing ball.

In the next step of process, step 314, the surgical site is allowed to heal before the device 10 is directly or indirectly connected to a denture. In general, a healing period of from about 3 to about 6 months is desirable.

After the desired time of healing, no additional surgical procedure is required, unlike the prior art process (which necessitated second stage surgery to remove the cover screw used in the process and to attach the prosthetic abutment). By comparison with prior art processes, applicant's prosthetic abutment is already attached.

At this stage of applicant's process, several options are available.

In one embodiment, illustrated in step 316 of U.S. Pat. No. 6,068,479, the healing ball is attached directly to a denture into which metal caps with an O-ring have been cured.

In another embodiment, illustrated in step 318, the healing ball is removed from the device 10. At this stage, several additional options are available.

One such option is to attach a gold cylinder to the device 10 in step 320.

26

Once the gold cylinder has been so attached, one may prepare a bar clip overdenture (see FIG. 12) and attach such denture to the superstructure (see step 322). Alternatively, in step 324, the gold cylinders can be incorporated into a fixed detachable implant supported bridge and thereafter secured to multiple implants in place in the jawbone.

Alternatively, in step 326, after the healing ball has been removed a gold coping may be attached to a tooth where such a gold coping is imbedded in the tooth. Thereafter, in step 328, such tooth is attached to the device 10.

It is to be understood that the aforementioned description is illustrative only and that changes can be made in the apparatus, in the ingredients and their proportions, and in the sequence of combinations and process steps, as well as in other aspects of the invention discussed herein, without departing from the scope of the invention as defined in the following claims.

What is claimed is:

1. A method for implanting a dental implant assembly comprising the steps of

making an incision into a gingival region of a patient, the gingival region having a gum-line;

producing a hole in a jawbone of the patient;

implanting a monolithic dental implant within the hole, wherein said monolithic dental implant is comprised of an abutment section and a base section monolithically joined to one another, wherein:

(a) said abutment section has a length of from about 1.5 to about 10 millimeters, the implanting step occurring such that a portion of the abutment length extends above the gum-line;

(b) said base section has a length of from about 3 to about 50 millimeters; and

(c) said base section is threaded;

machining the abutment section of the dental implant after it has been implanted within the hole such that a portion of the abutment section is removed, thereby altering its geometry; and

attaching a dental prosthesis directly to the altered abutment section.

2. The method as recited in claim 1, wherein said abutment section is comprised of a top abutment section and a bottom abutment section, wherein said abutment section extends downwardly and outwardly from said top abutment section to said bottom abutment section, the step of implanting the monolithic dental implant causing the bottom abutment section to be contiguous with the opening of the hole.

3. The method as recited in claim 1, wherein said base section is comprised of a top base section and a bottom base section, wherein said base section extends upwardly and outwardly from said bottom base section to said top base section, the step of implanting the monolithic dental implant causing the top base section to be fully disposed within the hole.

4. The method as recited in claim 1, wherein said base section is comprised of a bioactive coating comprised of a biologically active agent, the method further including the step of permitting the bioactive agent to interact with the jawbone of the patient.

5. The method as recited in claim 4, wherein said biologically active agent is selected from the group consisting of a bone morphogenetic protein, a basic fibroblast growth factor, a transforming growth factor, an osteogenic growth peptide, a hydroxyapatite, and combinations thereof.

6. The method as recited in claim 4, wherein said biologically active agent is a bone morphogenetic protein, the method further including the step of permitting the bioactive



27

agent to interact with the jawbone of the patient thereby promoting attachment of the base section to the jawbone.

7. The method as recited in claim 4, wherein said biologically active agent is comprised of a bone morphogenetic protein and a hydroxyapatite, the method further including the step of permitting the bioactive agent to interact with the jawbone of the patient thereby promoting attachment of the base section to the jawbone.

8. The method as recited in claim 1, further comprising a neck section disposed between, and monolithically joined with, said abutment section and said base section, wherein said neck section has a length of from about 0.1 to about 6 millimeters, the step of implanting the monolithic dental implant causing the neck section to be disposed above, but not within, the hole.

9. The method as recited in claim 1, wherein said abutment section is comprised of a roughened surface that has an average irregular roughness of from about 0.001 to about 1000 microns, the method further comprising the step of permitting the jawbone of the patient to attach to the roughened surface.

10. The method as recited in claim 8, wherein said neck section is comprised of parallel walls.

11. The method as recited in claim 10, wherein said base section is comprised of a roughened section that has a first average irregular roughness of from about 0.001 to about 1,000 microns.

12. The method as recited in claim 11, wherein said first average irregular roughness is from about 0.01 to about 1000 microns.

13. The method as recited in claim 11, wherein said first average irregular roughness is from about 3 to about 20 microns.

14. The method as recited in claim 11, wherein said neck section has a second average irregular roughness such that said first average irregular roughness of said base section is at least about two times as great as said second average roughness of said neck section.

15. A method for implanting a dental implant assembly comprising the steps of

implanting a monolithic dental implant abutment in the jawbone of a patient, wherein said monolithic dental implant abutment is comprised of an abutment section configured to receive an artificial tooth, a neck section, and a base section monolithically joined to one another such that said neck section is disposed between, and monolithically joined with, said abutment section and said base section, wherein:

said abutment section has a length of from about 1.5 to about 10 millimeters, the implanting step occurring such that at least half of the abutment length extends above the patient's gum-line;

said abutment section has a diameter of from about 1 to about 12 millimeters;

28

said base section has a length of from about 3 to about 50 millimeters;

said base section has a diameter of from about 1 to about 12 millimeters;

said base section is threaded;

said neck section has a length of from about 0.1 to about 6 millimeters and is comprised of parallel walls;

said neck section has a diameter of from about 1 to about 12 millimeters;

machining the abutment section of the dental implant after it has been implanted such that a portion of the abutment section is removed, thereby altering its geometry; attaching a dental prosthesis directly to the altered abutment section.

16. The method as recited in claim 15, wherein said abutment section is comprised of a multiplicity of walls monolithically joined to said abutment section.

17. The method as recited in claim 16, wherein said multiplicity of walls is comprised of a first wall that it is substantially perpendicular to said neck section.

18. The method as recited in claim 17, wherein said multiplicity of walls is comprised of a second wall that is substantially perpendicular to said neck section.

19. The method as recited in claim 15, wherein said abutment section is further comprised of a bore that extends into said abutment section a distance of from about 1.5 to about 10 millimeters.

20. A method for implanting multiple dental implants comprising the steps of

making an incision into a gingival region of a patient, the gingival region having a gum-line;

producing first and second holes in a jawbone of the patient;

implanting first and second monolithic dental implants within the first and second hole respectively, wherein each of said monolithic dental implants are comprised of an abutment section and a base section monolithically joined to one another, wherein:

said abutment section has a length of from about 1.5 to about 10 millimeters, the implanting step occurring such that at least a portion of the abutment length extends above the gum-line;

said base section has a length of from about 3 to about 50 millimeters; and

said base section is threaded;

individually machining the abutment section of each of the first and second dental implants after they have been implanted within their respective holes such that a portion of each abutment section is removed, thereby altering each geometry; and

attaching a dental prosthesis directly to the altered abutment section.

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